STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010113	A. BUILDING: _____ B. WING _____	C 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE BLACK RIVER FALLS	525 E SECOND ST BLACK RIVER FALLS, WI 54615

(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 06/27/2025, Surveyor conducted a 14-day complaint investigation and licensure survey at Country Terrace Black River Falls. Data collection continued through 07/29/2025. The complaint was substantiated. Twenty-one deficiencies were identified. One of the 21 deficiencies was a repeat violation (see Statement of Deficiency (SOD) ENE911 dated 11/11/2019). Census: 5	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the facility and its operation complied with all laws governing the facility. Findings include: On 06/09/2025, the Department received a complaint regarding the lack of adequate care for residents. The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.	N 196		

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

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N 196	Continued From page 1 On 06/27/2025 at 9:20 AM, Surveyor interviewed Director A. Director A stated s/he was still trying to clean up the mess when s/he started his/her role as director in February 2025. Director A stated s/he had an assistant director and oversaw two facilities in the area, including this one. Director A stated s/he was back and forth between the two facilities. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. Director A stated Registered Nurse (RN) E started this spring and oversaw all the company's facilities. On 06/27/2025 at 12:30 PM, Director A approached Surveyor and stated s/he had to leave the facility for the rest of the day due to a personal obligation. Director A stated Assistant Director (AD) I already had left for the day, but gave Surveyor his/her personal phone number if Surveyor needed to reach him/her. Director A left Surveyor with staff and resident records to review. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting documentation, including safety inspections, policy and procedures, staff training, and records for Resident 1 and Resident 2. Surveyor gave a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor received some documentation, including staff schedules, some safety inspections, and some staff training. On 07/02/2025 at 11:11 AM, Director A sent an email that indicated the provider did not have	N 196		

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N 196	Continued From page 2	N 196		

residents from April 2021 to 07/03/2024.

On 07/17/2025 at 2:04 PM, Surveyor again requested documentation, including safety inspections not received previously, policy and procedures, staff training not received previously, and additional records for Resident 1 and Resident 2, with a deadline of 2:00 PM on 07/21/2025.

By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.

On 07/22/2025 at 1:10 PM, Surveyor requested to schedule an exit conference with Director A.

On 07/22/2025 at 1:58 PM, Surveyor received an emailed read receipt from Director A, but did not receive a response back to schedule an exit conference.

As a result of the survey conducted on 06/27/2025, the complaint was substantiated, 21 deficiencies were identified and the following issues were identified during the course of the survey:
- Communicable disease screening for staff was not completed prior to hire.
- All employee training in resident rights; recognizing, preventing, managing and responding to challenging behaviors (CB); and client groups (CG) within 90 days after starting employment, was not completed.
- Continuing education was not completed.
- All parties were not involved in service plan development.
- Service plans were not updated when changes occurred.
- The onsite review of the provider's medication

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administration and medication storage systems was not completed.
- The scheduled psychotropic medication review was not completed quarterly.
- The PRN (as needed) psychotropic medication review was not completed monthly.
- RN delegation was not completed.
- Resident cares were not completed.
- Hand hygiene was not performed in accordance with the Centers for Disease Prevention and Control (CDC) standards.
- Raw meat was not thawed in a safe manner.
- The heating system was not maintained.
- There were combustibles within 3 feet of the furnace and water heater.
- Quarterly fire drills and an annual simulated sleeping hours fire drill were not completed as required.
- Safety drills (other than fire) were not completed semi-annually as required.
- The smoke detectors were not checked monthly.

On 07/30/2025, Surveyor sent Director A and Licensee H an email relaying what may be on the Statement of Deficiency (SOD).

Cross references:
N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease
N0243 DHS 83.21(1)-(3) All Employee Training
N0247 DHS 83.22(1)-(4) Task Specific Training
N0277 DHS 83.25 Continuing Education
N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation
N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved
N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes
N0404 DHS 83.37(1)(e) Medication Regimen,

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N 196	Continued From page 4 Administration Review N0407 DHS 83.37 (1)(h) Scheduled Psychotropic Medications N0408 DHS 83.37(1)(i) Prn Psychotropic Medication N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By Rn N0425 DHS 83.38(1)(a) Personal Care N0431 DHS 83.38(1)(g) Health Monitoring N0441 DHS 83.39(3) Hand Washing N0452 DHS 83.41(3)(b) Food Safety N0504 DHS 83.46(1)(c) Heating System Maintenance N0507 DHS 83.46(1)(f) Combustibles N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0534 DHS 83.48(1)(a) Smoke Detection System	N 196		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by:	N 220		

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N 220	Continued From page 5 Based on record review and interview, the provider did not ensure each staff member had documentation of being screened for communicable disease, including tuberculosis (TB), within 90 days of being hired. This was discovered for 2 of 3 sampled caregivers. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed Caregiver B's and Caregiver C's files. Caregiver B was hired on 09/20/2023. Caregiver B's file contained a TB test result completed on 09/22/2023. Caregiver B's file indicated Caregiver B started working directly with residents on 09/20/2023, before his/her TB test results were completed. Caregiver C was hired on 09/06/2024. Caregiver C's file contained a screening for TB, but the form did not contain documentation of the TB screening result, date, and signature of the healthcare provider conducting the screening. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting Caregiver C's TB test result, with a deadline by 5:00 PM on 07/01/2025.	N 220		

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N 220	Continued From page 6 By 5:00 PM on 07/01/2025, Surveyor did not receive Caregiver C's TB test result.	N 220		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of	N 243		

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N 243	Continued From page 7 property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers sampled obtained all training as required within 90 days after starting employment. Caregiver B did not have training in resident rights (RR) within 90 days after starting employment. Caregiver B did not have training in recognizing, preventing, managing and responding to challenging behaviors (CB) within 90 days after starting employment. Caregiver B did not have training in required client groups (CG) within 90 days after starting employment. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed Caregiver B's file. Caregiver B was hired on 09/20/2023. Caregiver B's file did not contain evidence of	N 243		

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N 243	Continued From page 8 training upon hire, or evidence of meeting an exemption for RR, CB and CG. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. On 07/22/2025 at 1:10 PM, Surveyor requested an exit conference with Director A and would have asked about Caregiver B's training upon hire. By 1:58 PM on 07/22/2025, Surveyor received a message indicating Director A had read the email, but did not receive any response from Director A. The provider did not ensure staff completed all required training within 90 days of starting employment.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident '	N 247		

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N 247	Continued From page 9 s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees obtained all task specific training. Caregiver B, who performs dietary duties, did not have training in dietary services within 90 days after assuming these job duties. Findings include: On 06/27/2025 at 9:05 AM, Surveyor interviewed Caregiver C. Caregiver C stated staff duties included housekeeping, preparing and serving food, and activities. Caregiver C stated the overnight shift typically helped to prep food for the following day.	N 247		

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N 247	Continued From page 10 On 06/27/2025, Surveyor requested dietary training for Caregiver B. Dietary Training The record for Caregiver B, hired on 09/20/2023, did not contain evidence of training upon hire or evidence of meeting an exemption for dietary training. On 06/27/2025, Surveyor reviewed the staff schedule, which indicated Caregiver B typically worked the overnight shift and would be responsible for prepping food. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. On 07/22/2025 at 1:10 PM, Surveyor requested an exit conference with Director A and would have asked about Caregiver B's training upon hire. By 1:58 PM on 07/22/2025, Surveyor received a message indicating Director A had read the email but did not receive any response from Director A.	N 247		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related	N 277		

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N 277	Continued From page 11 training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 staff sampled, completed at least 15 hours of continuing education requirements in 2024. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed Caregiver B's file. Caregiver B was hired on 09/20/2023. Caregiver B's record did not indicate Caregiver B had any continuing education in 2024. Caregiver B's record contained approximately 7 certificates of training completed for 2025, but did not contain the amount of time it took to complete them. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting Caregiver B's continuing education for 2024, with a deadline by 5:00 PM on 07/01/2025.	N 277		

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N 277	Continued From page 12 By 5:00 PM on 07/01/2025, Surveyor did not receive 2024 continuing education for Caregiver B. On 07/17/2025 at 2:04 PM, Surveyor again requested Caregiver B's continuing education for 2024, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 277		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was screened for clinically apparent communicable disease, including tuberculosis (TB), 90 days before or 7	N 302		

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N 302	Continued From page 13 days after admission. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor requested to review Resident 1's record. Resident 1 had an admission date of 04/30/2025. Resident 1's record contained a medical note, dated 11/06/2023, when a chest x-ray was completed. The record did not contain any other evidence that a communicable disease screening or TB test was done 90 days before or 7 days after Resident 1's admission. On 07/17/2025 at 2:04 PM, Surveyor requested Resident 1's communicable disease screening and TB test upon admission, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 302		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal	N 387		

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(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 387	Continued From page 14 illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was involved in developing the individual service plan (ISP), when the ISP was not signed by the resident or the resident's legal representative, as appropriate, acknowledging their involvement in, understanding of, and agreement with, the plan. Findings include: On 06/09/2025, the Department received a complaint regarding resident care. On 06/27/2025 at approximately 1:18 PM, Surveyor reviewed Resident 1's file. Resident 1 had an admission date of 03/22/2025. The ISP, dated 03/21/2025, was not signed by the resident or the resident's legal representative. The ISP was updated under the 6-month progress review, with no date specified, and was not signed by the resident or the resident's legal representative. On 07/17/2025 at 2:04 PM, Surveyor requested documentation, including the date Resident 1's ISP was last updated and the signature page,	N 387		

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	0010113	A. BUILDING: _____ B. WING _____	C 07/29/2025

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N 387	Continued From page 15 with a deadline by 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider. On 07/17/2025 at 4:39 PM, Surveyor interviewed Power of Attorney for Health Care (POAHC) G. POAHC G stated s/he had only been involved in one care team meeting with Assistant Director (AD) I since Resident 1's admission on 03/22/2025. POAHC G stated s/he was not informed when care team meetings were held. POAHC G stated Resident 1 had a rapid decline in health. POAHC G stated Resident 1 was on and off hospice in the past few months and Resident 1 had passed away on 07/11/2025.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and	N 389		

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N 389	Continued From page 16	N 389		

interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated to reflect Resident 1's health changes.

This is a repeat deficiency. See Statement of Deficiency ENE911 dated 11/11/2019.

Findings include:

On 06/09/2025, the Department received a complaint regarding resident care.

On 06/27/2025 at 9:45 AM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had a urinary foley catheter, and needed to be repositioned every 2 hours due to being on bed rest. Caregiver D stated Resident 1 was on precautions for Clostridioides difficile (C. diff).

On 06/27/2025 at 10:20 AM, Surveyor observed Caregiver C and Caregiver D perform cares for Resident 1. Surveyor observed a cart outside Resident 1's room with gloves and masks. Surveyor observed Caregiver C and Caregiver D reposition Resident 1 and apply a powder and barrier cream to his/her bottom. Surveyor observed Resident 1 had a urinary foley catheter and dry flaky skin on his/her legs.

On 06/27/2025 at 10:54 AM, Surveyor interviewed Director A. Director A stated that upon admission, Resident 1 was able to sit in a wheelchair moving him/herself around. Resident 1 had a quick decline since admission and now cannot get out of bed. Director A stated Resident 1 had been in and out of the hospital for urinary tract infections (UTIs) since admission. Director A stated Resident 1 had been on hospice for a short time prior to his/her last hospitalization and family was deciding if they wanted to put him/her

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N 389	Continued From page 17 back on hospice at this time. On 06/27/2025 at 12:55 PM, Surveyor interviewed Caregiver C. Caregiver C stated that to prevent bedsores, it was new for staff to be repositioning Resident 1. On 06/27/2025 at approximately 1:18 PM, Surveyor reviewed Resident 1's file. Resident 1 had an admission date of 03/22/2025. A staff progress note dated 06/13/2025, indicated hospice came to give Resident 1 a bed bath and observed his/her groin and buttocks were all red and bleeding. Hospice ordered Resident 1 to be changed every 2 hours. A hospital discharge note dated 06/23/2025, indicated Resident 1 had severe excoriation to his/her peri area due to C. diff diarrhea. The note read, in part, "Now that diarrhea has resolved we will back down on protective creams and transition to nystatin powder twice daily scheduled. Continue Foley catheter until skin is healed." The note indicated a barrier cream should be used on Resident 1's skin and Resident 1 was prescribed nystatin topical powder to be applied on the skin 3 times per day. The ISP was dated 03/21/2025 and was updated under the 6-month progress review, with no date specified. The ISP indicated Resident 1's skin was intact and no changes were noted when the ISP was last updated. The ISP did not address Resident 1's skin breakdown, precautions for C. diff, urinary foley catheter, repositioning, and hospice. The ISP did not reflect interventions or provide directives to staff.	N 389		

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N 404	Continued From page 18	N 404		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an onsite review of the facility's medication administration and medication storage systems were completed in 2024, by a physician, pharmacist or registered nurse. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible	N 404		

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N 404	Continued From page 19 dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor requested the 2023 and 2024 annual onsite reviews of the provider's medication system. Surveyor did not receive any annual onsite reviews of the provider's medication system On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting annual onsite reviews of the provider's medication system for 2023, 2024, and 2025, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive any annual onsite reviews of the provider's medication system for 2023, 2024, and 2025. On 07/02/2025 at 11:11 AM, Director A sent an email that indicated the provider did not have residents from April 2021 to 07/03/2024. On 07/17/2025 at 2:04 PM, Surveyor again requested annual onsite reviews of the provider's medication system for 2024 and 2025, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 404		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a	N 407		

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N 407	Continued From page 20 pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed that received a scheduled psychotropic medication, were assessed at least quarterly by a registered nurse (RN), pharmacist or practitioner, for the desired response and possible side effects of the medications. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 03/20/2025. Resident 1 had diagnoses that included a history of cerebrovascular accident (stroke) with right-sided hemiparesis and expressive aphasia with cognitive deficits, and major depression. Resident 1's medication pass history from March 2025 to June 2025, indicated Resident 1 was on the following scheduled psychotropic medication:	N 407		

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N 407	Continued From page 21 Sertraline HCL 100 mg - take one tablet daily at 8:00 AM. The medication pass history indicated Resident 1 had been administered this medication since admission on 03/20/2025. The Behavior Monitoring Log from March 2025 to June 2025, indicated the provider was monitoring Resident 1's use of Sertraline for depression each shift since admission on 03/20/2025. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated Registered Nurse (RN) E started this Spring and oversaw all the company's facilities. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A, requesting Resident 1's psychotropic medication reviews since admission, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive any psychotropic medication reviews. On 07/17/2025 at 2:04 PM, Surveyor again requested psychotropic medication reviews since admission, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF	N 408		

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N 408	Continued From page 22 shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on interview and record review, for as needed (PRN) psychotropic medications, the provider did not review the rationale for use, describe the behaviors that indicated a need for them, record possible negative side effects, monitor for inappropriate use, or document and conduct monthly reviews, for 1 of 1 resident reviewed that was prescribed a PRN psychotropic medication. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed Resident 1's file.	N 408		

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N 408	Continued From page 23 Resident 1 was admitted on 03/20/2025. Resident 1 had diagnoses that included a history of cerebrovascular accident (stroke), with right-sided hemiparesis and expressive aphasia with cognitive deficits, and major depression. Resident 1's medication pass history from March 2025 to June 2025, indicated Resident 1 was on the following PRN psychotropic medication: Hydroxyzine HCL 25 mg - take one tablet every 8 hours as needed for pain. The medication pass history indicated Resident 1 had been administered this medication approximately 16 times from March 2025 to June 2025. The Behavior Monitoring Log from March 2025 to June 2025 indicated the provider was monitoring Resident 1's use of Hydroxyzine for anxiety each shift since admission on 03/26/2025. The log indicated the provider started to monitor Resident 1's use of Hydroxyzine for hallucination each shift on 04/20/2025. The log indicated the provider started to monitor Resident 1's use of Hydroxyzine for agitation each shift on 05/01/2025 and they were no longer monitoring Hydroxyzine for hallucinations. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated Registered Nurse (RN) E started this Spring and oversaw all the company's facilities. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting Resident 1's psychotropic medication reviews since admission, with a deadline of 5:00 PM on 07/01/2025.	N 408		

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N 408	Continued From page 24 By 5:00 PM on 07/01/2025, Surveyor did not receive any psychotropic medication reviews. On 07/17/2025 at 2:04 PM, Surveyor again requested psychotropic medication reviews since admission, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider. The provider did not monitor at least monthly for the inappropriate use of PRN psychotropic medication.	N 408		
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 record review and interview, the provider did not ensure unlicensed staff were delegated by a registered nurse (RN) prior to administering medications or treatments via injection, nebulizer, stomal/enteral routes, or vaginal/rectal routes. One of 3 caregivers (Caregiver B) did not have documentation of completed delegation.	N 416		

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N 416	Continued From page 25 Findings include: On 06/27/2025 at 9:20 AM, Surveyor interviewed Director A. Director A stated s/he was still trying to clean up the mess when s/he started his/her role as director in February 2025. On 06/27/2025, Surveyor reviewed Caregiver B's file. Caregiver B was identified as a medication passer. Caregiver B's record contained a RN delegation completed on 03/13/2019. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. Director A stated RN E started this Spring and oversaw all the company's facilities. Director A stated RN E was responsible for completing employee RN delegation. Director A stated Caregiver B had his/her RN delegation completed. On 06/27/2025 at 12:25 PM, Surveyor interviewed Director A. Director A stated that when s/he started, s/he had to redo all the employee files. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting RN delegation for Caregiver B, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive RN delegation for Caregiver B. On 07/17/2025 at 2:04 PM, Surveyor again requested RN delegation for Caregiver B, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not	N 416		

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N 416	Continued From page 26 receive any further documentation from the provider.	N 416		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide personal care services adequate to meet the needs of Resident 2. Findings include: On 06/09/2025, the Department received a complaint regarding resident care. The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.	N 425		

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N 425	Continued From page 27 On 06/27/2025 at approximately 9:10 AM, Surveyor observed Resident 2 sitting at a dining room table eating breakfast. On 06/27/2025 at 10:02 AM, Surveyor observed Resident 2 still sitting at the same dining room table with his/her head tilted down, sleeping. On 06/27/2025 at 11:41 AM, Surveyor observed Resident 2 still sitting at the same dining room table with a book and a couple fidgets. On 06/27/2025 at 1:08 PM, Surveyor observed Resident 2 still sitting at the same dining room table with his/her head down, falling asleep. Caregiver D came walking by and attempted to clear his/her lunch bowl from the table, but Resident 2 stopped him/her and continued to feed him/herself. Surveyor observed Caregiver D walk away to do other tasks. On 06/27/2025 at approximately 2:50 PM, Surveyor observed Resident 2 still sitting at the same dining room table, reading a book. On 06/27/2025 at 3:00 PM, Surveyor interviewed Caregiver E. Caregiver E stated Resident 2 was not on a toileting schedule and they usually would take him/her to the bathroom right before dinner. On 06/27/2025 at approximately 1:18 PM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 04/30/2025. Resident 2 had a guardian and was protectively placed. Resident 2 had diagnoses that included schizophrenia, altered mental status, dementia, and cognitive impairment. The individual service plan (ISP), dated 05/02/2025, indicated Resident 2 required	N 425		

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N 425	Continued From page 28 24-hour supervision and was unable to make his/her needs known. The ISP indicated Resident 2 required 2 staff to assist with toileting using an EZ stand. The ISP indicated Resident 2 was incontinent of bladder and bowel. The ISP indicated Resident 2 was dependent with mobility in a wheelchair. The ISP indicated Resident 2 was independent with eating and was on a pureed diet. Staff were to give Resident 2 one food item at a time in a bowl with a small spoon to slow down his/her eating. The Physician Plan of Care dated 04/24/2025, indicated Resident 2 was to have supervision with meals. A care summary received 04/30/2025, indicated Resident 2 was to be toileted every 2 hours. The June 2025 Plan of Care Kardex indicated Resident 2 was incontinent on the day shift and had no bowel movement. It did not indicate the time Resident 2 was last toileted. It did not indicate Resident 2 needed supervision with eating and if Resident 2 was on toileting checks. Staff did not consistently sign off on care provided to Resident 2 during their shift, with 7 shifts not initialed by staff. On 07/17/2025 at 3:41 PM, Surveyor interviewed Guardian K. Guardian K indicated Resident 2's physical health had been deteriorating. Guardian K indicated his/her expectation would be for staff to assist Resident 2 with toileting approximately 6 times per day as s/he was incontinent of urine and bowel. Guardian K stated Resident 2 had a history of eating quickly and placing too much food in his/her mouth at one time without chewing. Guardian K stated Resident 2 was to be repositioned in his/her chair if s/he started	N 425		

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N 425	Continued From page 29 slouching. Surveyor was present at the facility from 9:03 AM to 3:15 PM, over 6 hours, and did not observe staff move Resident 2 from the dining room table, reposition Resident 2 in his/her wheelchair, and/or toilet Resident 2 during that time. Surveyor reviewed documentation in the dining room and observed a few times where staff would leave Resident 2 unsupervised when s/he still had a bowl of food in front of him/her.	N 425		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health	N 431		

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N 431	Continued From page 30 status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor Resident 1's health when it failed to communicate and record Resident 1's changes in condition. Resident 1 started to develop new skin breakdown to his/her groin and buttocks, which had not been communicated to hospice, the healthcare provider or Guardian G. Findings: On 06/09/2025, the Department received a complaint regarding resident care. The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025 at 9:35 AM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 was to be repositioned every 2 hours, had a urinary foley catheter, and staff were to encourage fluid intake. On 06/27/2025 at 10:54 AM, Surveyor interviewed Director A. Director A stated that a few months prior to Resident 1's admission, s/he was living in his/her own apartment. Director A stated that since his/her admission, Resident 1 had been in and out of the hospital multiple times for urinary tract infections (UTIs). Director A stated Resident 1 was on hospice for less than 1 week when s/he was hospitalized again to treat an infection in his/her urine. Director A stated that after this last hospitalization, s/he was willing to	N 431		

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N 431	Continued From page 31 take Resident 1 back as long as s/he was enrolled with hospice. Director A stated Resident 1 was discharged back, but family was unsure if they wanted to put him/her back on hospice and wanted to wait 2 more weeks. Director A indicated Resident 1's care team was aware they were not able to provide the level of care Resident 1 needed. Director A stated they were unable to meet Resident 1's needs and that s/he was beyond the care they could provide for him/her. Director A stated s/he felt like s/he was "failing" Resident 1. Surveyor asked Director A about Resident 1's skin breakdown. Director A stated that every time Resident 1 came back from the hospital, s/he had skin breakdown. Director A stated Resident 1 had been bedridden since 06/23/2025. On 06/27/2025 at 12:55 PM, Surveyor observed Caregiver C and Caregiver D provide cares to Resident 1. Surveyor observed dried stool on Resident 1's sheets, under the chuck pad, that were covered up by the chuck pad and left unchanged. Surveyor observed dried stool on Resident 1's urinary Foley catheter leg strap that was left unchanged. Surveyor observed Resident 1's buttocks, which had an open sore and peeling skin on both sides of his/her buttocks. Surveyor observed Caregiver C apply barrier cream to those areas. Caregiver C applied nystatin powder to Resident 1's groin. Caregiver C stated Resident 1 received a bed bath once to twice per week and staff were repositioning him/her every 2 hours. Caregiver C stated they tried to keep Resident 1's cares to a minimum because s/he experienced a lot of pain with movement. Caregiver C stated Resident 1 did not let staff do his/her hair or brush his/her teeth, because Resident 1 would bite or scream.	N 431		

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On 06/27/2025 at approximately 1:18 PM, Surveyor reviewed Resident 1's file. Resident 1 was admitted on 03/20/2025. Resident 1 had diagnoses that included a history of cerebrovascular accident (stroke) with right-sided hemiparesis and expressive aphasia with cognitive deficits and chronic kidney disease.

The pre-admission assessment dated 03/20/2025, indicated Resident 1 had no skin issues and had a urinary Foley catheter upon admission.

An undated pressure ulcer risk assessment done by Director A, indicated Resident 1 was at a high risk for skin breakdown and a prevention protocol should have been initiated.

The ISP was dated 03/21/2025 and was updated under the 6-month progress review, with no date specified. The ISP indicated Resident 1 required total assistance with bathing and typically refused. The ISP indicated Resident 1 refused oral care. The ISP indicated Resident 1 was bedridden and used a Hoyer lift for transfers. The ISP indicated Resident 1 could no longer use his/her arms. The ISP indicated Resident 1 had hallucinations, paranoia, and disorientation. The ISP indicated Resident 1 would refuse cares by yelling at staff and making gestures. The ISP indicated Resident 1's skin was intact and no changes were noted when the ISP was last updated. The ISP did not address Resident 1's skin breakdown, precautions for Clostridioides difficile (C. diff), urinary Foley catheter, repositioning, and hospice. The ISP did not reflect interventions or provide directives to staff.

The shower schedule indicated Resident 1 was to be bathed by hospice on Wednesdays and

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Saturdays during the evening shift.

The May 2025 plan of care Kardex indicated Resident 1 received a shower on 05/04/2025 and 05/08/2025. Resident 1 was hospitalized from 05/23/2025 to 06/02/2025.

The May 2025 shower day worksheet/body audit form indicated Resident 1 had no skin concerns on 05/04/2025. The 05/08/2025 form indicated Resident 1 had old bandages on his/her feet that were removed, and new ones were applied.

The June 2025 plan of care Kardex indicated Resident 1 received a shower on 06/03/2025 and 06/13/2025. Resident 1 was hospitalized from 06/13/2025 to 06/23/2025.

The June 2025 shower day worksheet/body audit form indicated Resident 1 had redness under his/her abdominal folds on 06/03/2025. On 06/13/2025, the form indicated Resident 1 had open bleeding sores in his/her groin and buttock area.

An After Visit Summary (AVS) dated 06/02/2025, indicated Resident 1 was hospitalized from 05/23/2025 to 06/02/2025, with an admission diagnosis of mental status changes. The AVS indicated Resident 1 tested positive for C. diff on 05/28/2025. A Braden Scale Score of 12 was documented on 06/02/2025, which indicated Resident 1 was a high risk for skin breakdown. The physician admission note dated 05/23/2025, read, in part, "[Resident 1] has some skin issues on [his/her] buttocks and sacrum during our evaluation. Foley catheter may have been placed to protect the skin." A physician progress note dated 05/30/2025, indicated Resident 1 had diarrhea 05/28/2025 and 05/29/2025 in the

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hospital. The progress note indicated wound care was consulted for pressure wounds to Resident 1's buttocks and sacrum.

A staff progress note dated 06/09/2025, indicated Resident 1 was sent to the emergency room (ER) for a fever. The notes indicated Resident 1 was diagnosed with a UTI and had an order for nystatin powder to be applied to his/her groin and peri area for yeast.

The June 2025 Medication Administration Record (MAR) indicated staff started to apply nystatin powder to Resident 1's groin three times per day on 06/10/2025.

A hospice admission dated 06/11/2025, indicated Resident 1 was admitted to hospice on 06/11/2025, until s/he was hospitalized on 06/13/2025 to 06/23/2025.

A staff progress note dated 06/13/2025, indicated hospice came to give Resident 1 a bed bath and observed his/her groin and buttocks were red and bleeding. Hospice ordered Resident 1 to be changed every 2 hours. Resident 1 was sent to the hospital to receive intravenous antibiotics for 7 to 10 days for his/her UTI, due to cultures coming back positive.

A hospital discharge note dated 06/23/2025, indicated Resident 1 had severe excoriation to his/her peri area due to C. diff diarrhea. The note read, in part, "Now that diarrhea has resolved we will back down on protective creams and transition to nystatin powder twice daily scheduled. Continue Foley catheter until skin is healed." The note indicated Desitin cream should be used on Resident 1's skin and Resident 1 was prescribed Nystatin topical powder to be applied

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on the skin 3 times per day.

On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A, requesting any incident reports for Resident 1 , wound charting, and hospice notes since admission, with a deadline of 5:00 PM on 07/01/2025.

By 5:00 PM on 07/01/2025, Surveyor did not receive any of the requested documentation for Resident 1.

On 07/17/2025 at 2:04 PM, Surveyor requested the following documentation, in part, for Resident 1, with a deadline of 2:00 PM on 07/21/2025:
- Date of pressure ulcer assessment
- ER (Emergency Room) visit documentation on 06/09/2025
- Shower documentation on 05/08/2025 mentioned bandages changed to feet; provide any further documentation about these wounds
- Any communication to care team since admission about behaviors, skin issues/wounds, refusal of cares, etc.
- Confirm hospitalization and ER dates since admission
- Confirm dates on hospice
- Hospice notes for time enrolled.

By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider for Resident 1.

On 07/17/2025 at 4:39 PM, Surveyor interviewed Guardian G. Guardian G stated Resident 1 had passed away on 07/11/2025. Guardian G stated the provider was not equipped to handle Resident 1. Guardian G stated Director A made it clear that they could not provide the level of care Resident 1 needed. Guardian G stated that every time

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someone would visit Resident 1, staff had to change him/her. Guardian G stated that one time in the hospital, Resident 1's teeth were "caked" with food debris and appeared they had not been brushed for weeks.

On 07/29/2025 at 11:18 AM, Surveyor interviewed Manager of Clinical Services (MOCS) N through hospice. MOCS N indicated Resident 1 was on hospice from 06/11/2025 to 06/13/2025. MOCS N indicated Resident 1 was readmitted to hospice on 07/01/2025, prior to Resident 1 passing away on 07/11/2025. MOCS N stated they did not have any notification from the provider about skin breakdown for Resident 1, indicated in the provider's staff progress note on 06/13/2025. MOCS N stated a note for 07/01/2025 indicated Resident 1 had stage 2 pressure injuries to his/her coccyx in two different areas and a reddened groin with nystatin powder applied.

On 07/29/2025 at 1:05 PM, Surveyor interviewed Case Manager (CM) L through the Managed Care Organization (MCO). CM L stated they last had a care team meeting with the provider on 06/23/2025. At that time, CM L stated the provider confirmed they could meet Resident 1's needs. CM L stated s/he only heard on 07/08/2025, from the hospice social worker, that the provider was struggling to meet Resident 1's needs. CM L indicated communication had been a struggle with Director A, where s/he would not reply to emails.

On 07/29/2025 at 2:20 PM, Surveyor interviewed Registered Nurse (RN) M through the managed care organization. RN M stated they were not notified about any skin breakdown for Resident 1 prior to his/her hospitalization on 06/13/2025.

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N 431	Continued From page 37 The provider did not monitor Resident 1's skin changes. Resident 1 had no skin breakdown upon admission on 03/20/2025, but was assessed to be a high risk for skin breakdown and a prevention protocol was not initiated. Resident 1's file had some skin breakdown documented, which included wounds to Resident 1's feet documented on 05/08/2025, and wounds to Resident 1's groin and buttocks documented on 06/03/2025 and 06/13/2025. Resident 1 had only 4 showers with skin assessments documented by staff for May and June 2025. By 07/01/2025, hospice indicated Resident 1 had a stage 2 pressure injury in two different areas of his/her coccyx. The provider did not retain documentation between Resident 1's care team regarding Resident 1's skin changes. Resident 1 passed away on 07/11/2025. Cross Reference N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 431		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure caregivers performed hand hygiene in accordance with the Centers for Disease Prevention and Control (CDC) standards. Caregiver D did not perform hand hygiene per CDC standards on 06/27/2025.	N 441		

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N 441	Continued From page 38 Findings include: The CDC provides the following recommendations for hand hygiene in healthcare settings: "Know when to clean your hands. - Immediately before touching a patient. - Before performing an aseptic task such as placing an indwelling device or handling invasive medical devices. - Before moving from work on a soiled body site to a clean body site on the same patient. - After touching a patient or patient's surroundings. - After contact with blood, body fluids, or contaminated surfaces. - Immediately after glove removal... On 06/27/2025 at approximately 9:45 AM, Surveyor asked Caregiver D about the cart with masks and gloves stationed outside Resident 1's room. Caregiver D stated Resident 1 had C. diff (Clostridioides difficile) and staff were to wear masks and gloves when in his/her room. According to the Wisconsin Department of Health Services website, "Clostridioides difficile, often called C. difficile or C. diff, is a type of bacteria that causes diarrhea and inflammation of the colon also called colitis. C. difficile can be spread through direct contact with someone who has a C. difficile infection or by someone who carries the bacteria but shows no signs or symptoms of infection (called colonization). C. difficile can also spread by touching surfaces or objects, such as medical equipment, that are contaminated with the bacteria. Washing hands with soap and water is the best way to prevent the spread of C. difficile from person to person. In health care settings, health care personnel should use contact	N 441		

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precautions to prevent the spread of C. difficile including wearing gowns and gloves. It's also important to clean surfaces and do laundry frequently to limit the spread." (Source: Wisconsin Department of Health Services, Clostridioides difficile (C. difficile), July 02, 2025, https://www.dhs.wisconsin.gov/disease/clostridioides-difficile.htm (retrieval date - July 23, 2025).)

On 06/27/2025 at 12:55 PM, Surveyor observed Caregiver C and Caregiver D provide cares to Resident 1. Surveyor observed Caregiver D apply gloves and wipe Resident 1's front peri area of stool. Both Caregiver C and Caregiver D rolled Resident 1 over and Caregiver D held Resident 1 with his/her soiled gloves while Caregiver C cleaned stool from Resident 1's bottom. Once Resident 1 was cleaned up and changed, Surveyor observed Caregiver C and Caregiver D boost Resident 1 up in bed with the same contaminated gloves on from cleaning his/her stool. Caregiver D offered Resident 1 water and took Resident 1's cup at his/her bedside with his/her soiled gloves out of the room to fill it up. Surveyor did not observe Caregiver D change his/her contaminated gloves or perform hand hygiene after completing peri care on Resident 1, prior to boosting him/her in bed and prior to filling up Resident 1's water cup.

On 07/01/2025, Surveyor received a fax from Director A that contained the hand washing policy and procedure. The policy and procedure read, in part, "The need for hand washing depends on the type, intensity and duration of resident contact or contact with articles considered contaminated. However, the following are examples of when hand washing is indicated:
-Before and after contact with a resident ...
-After touching excretions (feces, urine or

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COUNTRY TERRACE BLACK RIVER FALLS	525 E SECOND ST BLACK RIVER FALLS, WI 54615

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N 441	Continued From page 40 material soiled with them) or secretions from wounds. -Before handling resident's food, water and dishes ... -Before and after wearing gloves." Caregiver D did not perform hand hygiene per CDC standards by filling up Resident 1's water cup while wearing the same contaminated gloves used to complete peri care.	N 441		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored and served under sanitary conditions. A bag of frozen chicken	N 452		

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N 452	Continued From page 41 breasts was thawing at the bottom of the refrigerator. Findings include: On 06/27/2025 at 9:05 AM, Surveyor interviewed Caregiver C. Caregiver C stated staff duties included housekeeping, preparing and serving food, and activities. On 06/27/2025 at approximately 9:20 AM, Surveyor observed the menu for the day. The menu indicated chicken breast was to be served for dinner. On 06/27/2025 at approximately 9:40 AM, Surveyor observed chicken breast in a plastic zip lock bag thawing at the bottom of the refrigerator, with raw chicken juice pooling underneath. There was a zip lock bag of uncooked carrots and zip lock bag containing cooked ham sitting in the raw chicken juice. The SERVSAFE website indicates the following for safe food storage to prevent cross-contamination: "Store raw and ready-to-eat food separately if possible ...If separate storage is not possible, store food in the following top to bottom order: ready-to-eat food; seafood; whole cuts of beef and pork; ground meat and ground fish; whole and ground poultry." (Source: Servsafe, Preventing Cross-Contamination, https://www.servsafe.com/downloads/demos/fh/fh-sample-chapter (retrieval date - July 23, 2025).) On 06/27/2025 at 3:00 PM, Surveyor interviewed Caregiver E and Caregiver F. Caregiver E stated meat should be thawed in a tray at the bottom of the refrigerator.	N 452		

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N 452	Continued From page 42 On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting their meat thawing policy and procedure, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive the meat thawing policy and procedure. On 07/17/2025 at 2:04 PM, Surveyor again requested a meat thawing policy and procedure, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 452		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a heating contractor or local utility company completed maintenance service on the gas furnace at least every 3 years.	N 504		

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N 504	Continued From page 43 Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed the provider's safety binder. Surveyor did not locate a furnace inspection. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting the last furnace inspection, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive any furnace inspections. On 07/02/2025 at 11:11 AM, Director A sent an email that indicated the provider did not have residents from April 2021 to 07/03/2024. On 07/17/2025 at 2:04 PM, Surveyor again requested the last 2 furnace inspections, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 504		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by:	N 507		

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N 507	Continued From page 44 Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of the furnace and water heater. Findings include: On 06/27/2025 at approximately 9:45 AM, Surveyor observed both furnace rooms. The furnace room across from room number 10 had a shower chair and ladder stored next to the furnace. The furnace room by the living room had cardboard boxes, soft water salt bags, and other combustibles, within 3 feet of the furnace and water heater. On 06/27/2025 at 9:50 AM, Surveyor interviewed Director A about the items stored by the furnaces and water heater. Director A stated s/he understood the concern and would remove the items promptly.	N 507		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the	N 525		

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N 525	Continued From page 45 employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct fire evacuation drills at least quarterly, and did not conduct at least one fire evacuation drill annually that simulated the conditions during usual sleep hours. for calendar year 2024. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed the provider's safety binder. Surveyor did not locate any fire drills for 2023 and 2024. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A, requesting fire drills for 2023 and 2024, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive any fire drills for 2023 or 2024. On 07/02/2025 at 11:11 AM, Director A sent an email that indicated the provider did not have residents from April 2021 to 07/03/2024. On 07/17/2025 at 2:04 PM, Surveyor again requested fire drills for only 2024, with a deadline of 2:00 PM on 07/21/2025.	N 525		

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N 525	Continued From page 46 By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct other (other than fire) evacuation drills at least semi-annually for calendar year (2024). Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed the provider's safety binder. Surveyor did not locate any "other" evacuation drills for 2023 and 2024. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A requesting "other" evacuation drills for 2023 and 2024, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive any "other" evacuation drills for 2023 or 2024. On 07/02/2025 at 11:11 AM, Director A sent an	N 526		

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N 526	Continued From page 47 email that indicated the provider did not have residents from April 2021 to 07/03/2024. On 07/17/2025 at 2:04 PM, Surveyor again requested "other" evacuation drills for 2024, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider. Cross Reference N0525 DHS 83.47(2)(d) Fire Drills.	N 526		
N 534	83.48(1)(a) Smoke detection system. Except as provided under sub. (2), the CBRF shall have an interconnected smoke detection system pursuant to s. 50.035(2) Stats., and shall have an interconnected heat detection system to protect the entire CBRF so that if any detector is activated, an alarm audible throughout the building will be triggered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke detectors had been tested at least every other month by staff. This had the potential to affect 5 of 5 residents. Findings include: The provider is licensed to care for 17 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 06/27/2025, Surveyor reviewed the provider's safety binder. Surveyor did not locate smoke	N 534		

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N 534	Continued From page 48 detector tests for 2023 and 2024. On 06/27/2025 at 6:27 PM, Surveyor sent an email to Director A, requesting smoke detector tests for 2023, 2024, and 2025, with a deadline of 5:00 PM on 07/01/2025. By 5:00 PM on 07/01/2025, Surveyor did not receive any smoke detector tests for 2023, 2024, and 2025. On 07/02/2025 at 11:11 AM, Director A sent an email that indicated the provider did not have residents from April 2021 to 07/03/2024. On 07/17/2025 at 2:04 PM, Surveyor again requested smoke detector tests for only 2024 and 2025, with a deadline of 2:00 PM on 07/21/2025. By 2:00 PM on 07/21/2025, Surveyor did not receive any further documentation from the provider.	N 534		