| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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<br><br>On 10/03/2024, Surveyor conducted a verification visit, standard licensure survey and complaint investigation (x4) at Country Terrace Minocqua I. Data collection continued through 10/09/2024.<br><br>The deficiencies identified in statement of deficiency (SOD) DMXI14 were corrected.<br><br>Two of 4 complaints were substantiated.<br><br>Two deficiencies were identified.<br><br>The two deficiencies were repeat violations. See Statement of Deficiency (SOD) DMXI11, dated 05/16/2022, and SOD DMXI13, dated 08/09/2023.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 14 | {N 000} | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>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. | N 389 | | |

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 |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 389 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation and interview, the provider did not update Resident 1's and Resident 4's Individual Service Plans (ISP) annually or when there was a change in the resident's needs, abilities or physical or mental condition.<br><br>This deficiency is a repeat violation. See Statement of Deficiency (SOD) DMXI11, dated 05/16/2022.<br><br>Findings include:<br><br>The provider is licensed to care for up to 14 residents in the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, and advanced age. The facility is connected to the provider's licensed community based residential facility (CBRF), Country Terrace Minocqua II. The 2 CBRFs have a shared entrance, lounge area, dining room, and kitchen.<br><br>On 08/12/2024, the department received a complaint alleging resident care plans were not being followed or updated and a bed rail was being used as a restraint.<br><br>On 10/03/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 03/01/2024. Resident 4's ISP (dated 08/01/2024) noted, "Resident walks with walker but uses wheelchair more often..."<br><br>On 10/03/2024 at approximately 10:00 AM., Surveyor interviewed Resident 4 in his/her room. Surveyor observed Resident 4 sitting in a | N 389 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 389 | Continued From page 2 | N 389 | | |

wheelchair. Resident 4 denied having any concerns. Resident 4 stated s/he used his/her wheelchair to get around the facility.

On 10/03/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/01/2018. Resident 1's ISP noted, "Fall Risk - safety checks, pressure alarm on bed, pull alarm on wheelchair. **6 falls from June 2023 - August 2023. Waiting on repo (repositioning) bar from [son/daughter], MD (medical doctor) order on file.

On 10/03/2024, Surveyor observed a bed rail on Resident 1's bed. Resident 1 was not in his/her room.

On 10/03/2024 at approximately 11:05 AM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 used the bed rail to "reposition" himself/herself in his/her bed during cares. Caregiver D reported that Resident 1's son/daughter installed the bed rail and the son/daughter was very adamant about keeping the bed rail in place.

On 10/03/2024 at approximately 10:35 AM, Surveyor asked Director A if Resident 1's ISP addressed the use of a bed rail. Director A stated that the ISP did not address the use of a bed rail. Director A confirmed that Resident 1's ISP noted "waiting on repo bar from [son/daughter]. Director A verified that "repo" stood for "repositioning."

On 10/07/2024 at approximately 10:55 AM, Surveyor interviewed Caregiver B via telephone. Caregiver B reported that Resident 4 was not able to walk and used a wheelchair at all times to get around the facility.

On 10/08/2024 at approximately 11:46 AM,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 389 | Continued From page 3<br>Surveyor asked Director A via e-mail about when the bed rail was installed on Resident 1's bed and if an assessment was done prior to the bed rail being installed.<br><br>On 10/08/2024 at approximately 11:52 AM, Director A noted via e-mail, "There was a standard small grab bar on [his/her] bed when I started here a year and a half ago. About a year ago the [son/daughter] upgraded it for [him/her] to use to move in bed and help [him/her] sit up to stand. It was always up at the top of the bed until [s/he] broke [his/her] hip and [son/daughter] was using it to prevent [him/her] from falling out of bed. As for an assessment, I am unsure I can look for one in [his/her] red book and ask hospice. I know they have been talking with [son/daughter] about it since [s/he] started on hospice."<br><br>On 10/08/2024 at approximately 12:20 PM, Surveyor interviewed Director A via e-mail. Surveyor asked Director A if Resident 4 was able to walk with a walker per his/her ISP or if Resident 4 used a wheelchair for mobility?<br><br>On 10/08/2024 at approximately 2:15 PM, Director A noted via e-mail, "When [Resident 4] first came in [s/he] was walking with [his/her] walker to the bathroom but has declined and doesn't have the strength to walk with the walker. [S/he] pivots with assist of one or two. [S/he] uses (a) wheelchair to ambulate in [his/her] room and dining area. [His/Her] ISP needs update.<br><br>On 10/09/2024 at approximately 10:00 AM, Surveyor interviewed Director A via telephone. Director A reported that Director A planned to speak to Resident 1's son/daughter about the use of a bed rail and Resident 1's ISP will be updated | N 389 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 389 | Continued From page 4<br>to address the use of a bed rail as a repositioning tool during cares.<br><br>The provider did not update Resident 1's and Resident 4's ISP when there were changes in conditions and abilities. | N 389 | | |
| N 396 | 83.36(1)(a) Adequate staff to meet resident needs.<br><br>The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure employees were provided in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>This deficiency is being cited for the 3rd time. See Statement of Deficiency (SOD) DMXI11, dated 05/16/2022, and SOD DMXI13, dated 08/09/2023.<br><br>Findings include:<br><br>The provider is licensed to care for up to 14 residents in the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, advanced age. The facility is connected to the provider's licensed community based residential facility (CBRF), Country Terrace Minocqua II. The 2 CBRFs have a shared entrance, lounge area, dining room, and kitchen. Country Terrace Minocqua I will be referred to as "Side 1" and Country Terrace Minocqua II will be referred to as "Side 2." | N 396 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 396 | Continued From page 5<br>On 09/12/2024, the department received a complaint alleging the overnight (NOC) shift was staffed with two people and cares were not getting done.<br><br>On 10/03/2024 at approximately 10:35 AM, Surveyor interviewed Director A. Surveyor asked Director A about staffing schedules. Director A stated there was one schedule for both buildings (Side 1 and Side 2) and the schedule depicted which side staff were assigned to work. Surveyor asked Director A about the staffing pattern for Side 1 and Side 2. Director A reported that 4 staff worked on AM shift (6 AM - 2 PM), 4 staff worked on PM shift (2 PM - 10 PM), and 2 staff worked on NOC shift (10 PM - 6 AM). Director A indicated that 2 staff were assigned to work on Side 1 and 2 staff were assigned to work on Side 2 during the AM shift; 2 staff were assigned to work on Side 1 and 2 staff were assigned to work on Side 2 during the PM shift; 1 staff was assigned to work on Side 1 and 1 staff was assigned to work on Side 2 during the NOC shift. Director A noted that sometimes an extra staff person was scheduled to "float" between Side 1 and Side 2 during NOC shift. Surveyor asked Director A about resident cares and how many residents required the assistance of two staff members for cares and transfers. Director A stated that Resident 1, Resident 2 and Resident 3 required the assistance of two staff members for cares and/or transfers.<br><br>On 10/03/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/01/2018. Resident 1's individual service plan (ISP) noted that Resident 1 required the assistance of two staff for dressing and toileting.<br><br>On 10/03/2024, Surveyor reviewed Resident 2's | N 396 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 396 | Continued From page 6 | N 396 | | |

record. Resident 2 was admitted on 11/20/2019. Resident 2's ISP noted that Resident 2 "can not [sic] walk (and) is lifted by 2 staff or (a) sit to stand."

On 10/03/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 08/23/2024. Resident 3's ISP noted, "Resident is becoming increasingly weaker in [his/her] legs, needs 2 assist with pivots."

On 10/03/2024, Surveyor reviewed staff schedules from June 2024 to September 2024. The schedules indicated staff were assigned to work on Side I or Side II during the AM, PM and NOC shifts. The schedules indicated there were 2 staff scheduled to work on Side 1 and 2 staff scheduled to work on Side 2 during the AM shift and PM shift and there was 1 staff scheduled to work on Side 1 and 1 staff scheduled to work on Side 2 during the NOC shift.

On 10/07/2024 at approximately 10:55 AM, Surveyor interviewed Caregiver B via telephone. Caregiver B indicated that Caregiver B worked at the facility for the past seven years. Caregiver B indicated that s/he worked the NOC shift with Caregiver C. Caregiver B reported that the schedule indicated whether or not a caregiver worked on Side 1 or Side 2. Caregiver B stated that most of the time, a total of two staff worked NOC shift and covered Side 1 and Side 2. Surveyor asked Caregiver B if there were any residents that required the assistance of two people. Caregiver B reported that Resident 1, Resident 2, Resident 3 and Resident 4 required the assist of 2 people for cares, toileting and/or transfers.

On 10/09/2024 at approximately 10:00 a.m.,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0015554 | A. BUILDING: _____ B. WING _____ | R-C 10/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE MINOCQUA I | 8730 A PACKING PLANT RD MINOCQUA, WI 54548 |

| (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 396 | Continued From page 7<br><br>Surveyor interviewed Director A via telephone. Director A confirmed the facility had two separate licenses and tried to staff Side 1 and Side 2 with 2 people per shift. Director A stated that two people usually worked the NOC shift - 1 person on Side 1 and 1 person on Side 2. Director A commented, "We need another person on NOC [sic] shift."<br><br>The provider did not ensure sufficient staffing on a 24-hour basis to meet the needs of the residents at all times. | N 396 | | |