STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 On 08/01/2023, Surveyors conducted a standard licensure survey and complaint investigation (x2) at Country Terrace Minocqua II. Data collection continued through 08/09/2023. Six deficiencies were identified. The complaints (2) were substantiated. Census: 7	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, 6 of 7 residents did not receive all prescribed medications in the dosage and at intervals prescribed by a practioner. Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7 had medications left in the package that were not administered. The reason for the medication omissions was not documented. Resident 4 did not receive all of his/her antibiotics for a urinary tract infection (UTI), which may have resulted in her/him having to go to the emergency department 2 additional times for a UTI.	N 352		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 352	Continued From page 1 Findings include: On 06/26/2023, the Department received a complaint regarding medication administration, including allegations medications were left in bubble packs and a resident's UTI was not treated appropriately. On 08/01/2023 at approximately 9:15 a.m., Surveyor interviewed Caregiver D and observed the medication cart. Surveyor observed the scheduled medications were packaged in unit dose bubble cards. Each unit dose was numbered 1 - 31. Caregiver D told Surveyor staff administer the medication from the bubble pack on the date it was. As an example, that day was 08/01/2023, therefore staff administered the medication from the unit dose bubble that was numbered 1. On 08/01/2023 at approximately 11:00 a.m., Surveyor interviewed Assistant Director (AD) B and asked about medication errors. AD B told Surveyor Resident 3 had an antibiotic for a UTI, which was in a bottle instead of unit dose packaging. Staff signed off that they were administering the antibiotic but when the cycle was complete there was still medication left in the bottle. At approximately 2:15 p.m., Surveyor conducted an audit of the residents' scheduled medication cards with Caregiver D. Surveyor observed the following residents' medications that remained in the medication cards: Resident 2's 07/21/2023 and 07/30/2023 4:00 p.m. doses of risperidone remained in the medication card.	N 352		

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N 352	Continued From page 2	N 352		

Resident 3's 07/30/2023 PM dose of cephalexin remained in the medication card. His/her 07/29/2023 HS (nighttime) dose of acidophilus remained in the medication card. His/her 07/17/2023 - 07/25/2023 and 07/30/2023 doses of potassium remained in the medication card.

Resident 4's 07/19/2023 and 07/20/2023 AM doses of losartan remained in the medication card. His/her 07/20/2023 and 07/30/2023 4:00 p.m. doses of quetiapine remained in the medication card.

Resident 5's 07/15/2023 and 07/25/2023 HS doses of levetiracetam remained in the medication card. His/her 07/21/2023 AM dose of metoprolol remained in the medication card.

Resident 6's 07/21/2023 and 07/22/2023 8:00 p.m. doses of quetiapine remained in the medication card. His/her 07/24/2023 AM dose of metoprolol remained in the medication card.

Resident 7's 07/17/2023 and 07/20/2023 AM doses of calcium remained in the medication card. His/her 07/17/2023 AM doses of losartan and propranolol remained in the medication card.

On 08/01/2023 at approximately 2:30 p.m., Surveyor explained to Regional Nurse (RN) C, who was also the administrator, that Surveyor observed multiple medications for multiple residents that should have been administered, remained in the medication cards. RN C said s/he would have to review the medication administration records (MAR) to determine the reason the medications were not administered.

On 08/02/2023, Surveyor reviewed the residents' MARS and records and discovered the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 352	Continued From page 3 Resident 2: 07/21/2023 and 07/30/2023 - 4:00 p.m. doses of risperidone were initialed on the MAR as if they were administered. These medications remained in the medication cart. 07/31/2023 - AM doses of multivitamin, sertraline, risperidone, and acetaminophen were not signed off on the MAR as given. There was no explanation documented. 07/25/2023 - Staff administered PRN (as needed) lorazepam - no effectiveness was documented. 07/03/2023 and 07/21/2023 - staff administered PRN lorazepam, but no behaviors were documented on the behavior log. Resident 3: 07/17/2023 - AM medications: citalopram, fluticasone, omeprazole, solifenacin, vitamin D3, Eliquis were not initialed on the MAR as administered. There was no explanation documented. 07/20/2023 - AM medications: citalopram, fluticasone, omeprazole, solifenacin, vitamin D3, Eliquis, and potassium were not initialed on the MAR as administered. There was no explanation documented. 07/30/2023 - PM dose of cephalexin was initialed on the MAR as administered. This dose remained in the medication cart. 07/29/2023 - HS dose of acidophilus was not initialed on the MAR as administered. This dose remained in the medication cart. There was no explanation documented. 07/17/2023 - 07/25/2023 and 07/30/2023 PM doses of potassium were initialed on the MAR as administered. These doses of potassium remained in the medication cart. On 05/28/2023, Resident 3 was sent to the	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 352	Continued From page 4	N 352		

emergency department for abdominal pain and loose stools. S/he was diagnosed with a UTI and prescribed 2 antibiotics, amoxicillin, and nitrofurantoin-macro.

On 06/07/2023, staff faxed Resident 3's doctor, which read: "Res. (Resident) was sent out by ambulance to [hospital name] complaining of severe pain to [his/her] abd. (abdomen) on 5/28/23. [S/he] was seen by [Name] and diagnosed with severe UTI. [S/he] was prescribed Nitrofurantoin 100 mg (milligrams), 1 cap (capsule) 2x daily for 7 days and amoxicillin 500 mg, 1 cap. 2x daily for 10 days. Due to the meds (medications) being in bottles not bubble packed many of the doses were missed. [His/her] urine is still cloudy a [sic] foul smelling. Do you want to start a new course or have [him/her] be seen again?"

On 06/07/2023, the doctor returned a signed fax with orders: "U/A (urinalysis) today, send for culture." Surveyor did not review any notes that indicated staff obtained a urine sample for analysis and culture.

On 06/16/2023 at 12:45 p.m., staff documented: "Res. Not acting like [him/herself]. Shower and ADLs (activities of daily living) needed more help than usual. Writer took vitals and very high 1st ck (check) was 168/75 ckd (checked) an hour later and up to 209/78 pulse 113. Contacted POA (power of attorney) and said to send Res out by ambulance to get evaluated. Went to [Name] hospital."

On 06/16/2023 at 8:00 p.m., staff documented: "Res. Has UTI, new script for antibiotics is in top drawer of med cart in a bottle. Medicine to be given 2x daily 8AM & 8 PM."

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	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 352	Continued From page 5 On 07/22/2023, staff faxed Resident 3's doctor, which read: "Res. Sent in to [Name] ER (emergency room) d/t (due to) increased abdominal pain and loose stools x 3 days. Similar sx (symptoms) occurred the last time res. had a UTI." The after-visit summary, dated 07/22/2023, from the emergency department, indicated Resident 3 was diagnosed with a UTI and prescribed an antibiotic, cephalexin 500 mg, 1 capsule, by mouth, 3 times daily, for 10 days. Surveyor observed the 07/30/2023 PM dose of cephalexin remained in the bubble pack and was initialed on the MAR as administered. Resident 3 was sent to the emergency department 3 times for a UTI (05/28/2023, 06/16/2023, and 07/22/2023). Resident 4: 07/19/2023 - AM dose of losartan had staff initials circled on the MAR indicating the medication was not given. Surveyor requested the back of the MAR (and it was not provided) to see if there was documentation as to why it was not administered. The 07/19/2023 dose of losartan remained in the medication cart. 07/20/2023 - AM dose of losartan was initialed on the MAR as administered. The medication remained in the medication cart. 07/20/2023 - 4:00 p.m. dose of quetiapine was initialed on the MAR as administered. The medication remained in the medication cart. 07/30/2023 - 4:00 p.m. dose of quetiapine was not initialed on the MAR. There was no explanation documented. 07/29/2023 - 4:00 p.m. dose of quetiapine was	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 352	Continued From page 6	N 352		

not initialed on the MAR. There was no explanation documented.
07/28/2023 - staff administered PRN quetiapine. Surveyor did not receive the back of the MAR to see if staff documented a reason or effectiveness of medication. There was no behavior documented on Resident 4's behavior monitoring log on 07/28/2023.

Resident 5:
07/15/2023 - HS dose of levetiracetam had staff's initials circled on the MAR. Staff documented: "Out." The medication remained in the bubble pack.
07/21/2023 - AM dose of metoprolol was initialed on the MAR as administered. The medication remained in the medication cart.
07/25/2023 - HS dose of levetiracetam was initialed on the MAR as administered. The medication remained in the medication cart.
07/29/2023 and 07/30/2023 - AM medications were not documented on the MAR. There was no explanation documented.

Resident 6:
07/09/2023 - 8:00 p.m. dose of quetiapine was not initialed on the MAR. There was no explanation documented.
07/14/2023 - 8:00 a.m. doses of: aspirin, desvenlafaxine, loratadine, losartan, omeprazole, and polyethylene glycol were not documented as administered on the MAR. There was no explanation documented. His/her other 8:00 a.m. doses of vitamin D3, metoprolol and buspirone for 07/14/2023 were initialed on the MAR as administered.
07/21/2023 and 07/22/2023 - 8:00 p.m. doses of quetiapine were initialed on the MAR as administered. The medications remained in the medication cart.

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COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 352	Continued From page 7 07/24/2023 - AM dose of metoprolol was initialed on the MAR as administered. The medication remained in the medication cart. Resident 7: 07/17/2023 - AM doses of: calcium, losartan, and propranolol were initialed on the MAR as administered. These medications remained in the medication cart. 07/20/2023 - AM doses of: Tab-a-Vite (multivitamin), calcium, fish oil, losartan, pantoprazole, and propranolol were not signed as administered on the MAR. There was no explanation documented. The calcium for 07/20/2023 remained in the medication cart. 07/30/2023 - The noon dose of cephalexin had no documentation on the MAR. There was no explanation documented. The medication remained in the medication cart. 07/31/2023 - AM doses of: calcium, fish oil, losartan, and propranolol were not initialed on the MAR. There was no explanation documented. On 08/09/2023 at approximately 9:00 a.m., Surveyor interviewed Director A and RN C. Surveyor explained there were multiple medications that remained in the medication cart. Some of those medications were documented as given and some had no documentation. There were also blanks on residents' MARS without explanation. RN C said they did an audit after Surveyors left the facility on 08/01/2023 and discovered there was a pattern of medication errors with the same staff member working. S/he said that staff member was no longer allowed to administer medications until s/he received additional training.	N 352		

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	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 396	Continued From page 8	N 396		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: 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. This had the potential to affect all 7 residents that resided in the facility. Findings include: The provider is licensed to care for up to 10 residents in the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, and advanced age. The community based residential facility (CBRF) is connected to the provider's other licensed CBRF, Country Terrace Minocqua I. The 2 CBRFs have a shared entrance, lounge area, dining room, and kitchen. On 08/01/2023 at approximately 8:45 a.m., Surveyor interviewed Assistant Director (AD) B. AD B told Surveyor that the staff work both facilities at the same time. Surveyor asked what the staffing pattern was. AD B said they usually have 4 staff on AM shift, 2 or 3 staff on the PM shift, and 2 or 3 staff on the overnight shift. On 08/01/2023 at approximately 11:15 a.m., Surveyor interviewed AD B and asked if any of the residents in the building required more than 1 staff to assist them. AD B told Surveyor Resident 3 required the assist of 2 staff for transfers, 3 staff when s/he used the bathroom. S/he said	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 9	N 396		

Person O and Person K, who were residents from the adjacent facility, required the assist of 2 staff members for transfers.

On 08/03/2023, Surveyor reviewed the staff schedule for June and July 2023. The schedules indicated they were for facility #33. The schedules did not indicate if the staff were working in Country Terrace Minocqua I or Country Terrace Minocqua II.

The June 2023 schedule indicated that on a daily basis, there were 2 staff scheduled for both facilities during either the day, evening, and/or overnight shift. The July 2023 schedule indicated that for 26 out of 31 days, there were 2 staff scheduled to work both facilities during either the day, evening, and/or overnight shift.

On 08/03/2023 at approximately 12:30 p.m., Surveyor interviewed Caregiver M. Caregiver M said s/he normally worked the day shift. S/he said typically there were 4 staff on day shift but s/he has worked with as little as 2 staff. S/he said "a lot of times" there are 2 staff on the evening shift and that is when the residents have behaviors. Surveyor asked which residents required the assistance of 2 staff. Caregiver M said Resident 1 required 2 staff at times and Resident 3 required the assistance of 2 - 3 staff. S/he said that in the adjacent facility, Person O and Person K required the assistance of 2 staff. Surveyor asked Caregiver M, if 2 staff were working alone and they were assisting a resident that required 2 staff in Country Terrace Minocqua I, would that not leave Country Terrace Minocqua II with no staff? Caregiver M said that was "correct."

On 08/09/2023 at approximately 9:00 a.m., Surveyor interviewed Director A and Regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 396	Continued From page 10 Nurse (RN) C. RN C was also identified as the administrator. Surveyor asked for clarification on the schedule as to which staff worked in Country Terrace Minocqua I and which staff worked in Country Terrace Minocqua II. Director A said, "They all work in both sides." Surveyor asked which residents required the assistance of 2 staff for transfers. Director A confirmed what Caregiver M told Surveyor. Surveyor explained the concern that when 2 staff were scheduled to work in both facilities at the same time, and they assisted a resident that required 2 staff, they were leaving one of the facilities with no staff present. RN C responded that was the same as any large facility if 2 staff are in a room assisting a resident. Surveyor explained that this was not 1 large CBRF; it was 2 medium CBRFs and they were required to staff each CBRF to meet the needs of the residents. RN C confirmed that s/he understood. The provider did not ensure employees were provided on a 24-hour basis to meet the needs of 7 residents.	N 396		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate written schedule for staffing the community based residential facility (CBRF).	N 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 399	Continued From page 11 Findings include: The provider is licensed to care for up to 10 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 CBRF, Country Terrace Minocqua I. The 2 CBRFs have a shared entrance, lounge area, dining room, and kitchen. On 08/01/2023 at approximately 8:45 a.m., Surveyor interviewed Assistant Director (AD) B. AD B told Surveyor that the staff work both facilities at the same time. On 08/01/2023, Surveyor reviewed the staff schedule for June and July 2023. The schedules indicated they were for facility #33. They did not indicate if the staff were working in Country Terrace Minocqua I or Country Terrace Minocqua II. On 08/09/2023 at approximately 9:00 a.m., Surveyor interviewed Director A and Regional Nurse (RN) C. RN C was also identified as the administrator. Surveyor asked for clarification of which staff worked in which facility. Director A said, "They all work in both sides." Surveyor asked for clarification of which residents resided in Country Terrace Minocqua I and which residents resided in Country Terrace Minocqua II. RN C replied that they were not present in the facility and did not have the information at that time. Surveyor requested to have that information emailed by the end of day. Surveyor did not receive this information. According to the facility's floor plans. Country Terrace Minocqua I had a census of 8. Country Terrace Minocqua II had a	N 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B PACKING PLANT RD MINOCQUA, WI 54548

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N 399	Continued From page 12 census of 7. The provider did not maintain an accurate schedule to identify which staff were working in each CBRF.	N 399		
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 serve food under sanitary conditions on 08/01/2023. Findings include: On 07/20/2023, the Department received a complaint alleging unsanitary food preparation and service in the kitchen and hair being found in residents' food during mealtimes.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 452	Continued From page 13 This facility is connected to provider's adjacent licensed facility, Country Terrace Minocqua I (CTM I), via a shared entrance, kitchen, and dining room. Residents from both facilities eat meals in the shared dining room. According to the Wisconsin Food Code Fact Sheet (11/2020), "Employees can prevent foodborne illness by practicing good personal hygiene. This includes proper handwashing, maintaining fingernails, wearing hair restraints and proper clothing..." "Food employees are required to wear hair restraints such as hair nets, hats, and beard nets that are effective in keeping hair under control. (Wisconsin Department of Agriculture, Trade and Consumer Protection, https://www.datcp.wi.gov). On 08/01/2023, Surveyor interviewed Cook D. Cook D indicated that s/he was recently promoted to the kitchen lead. Cook D reported s/he manages the kitchen, is a caregiver and passes medications. Cook D indicated s/he takes care of everything in the kitchen from ordering food to preparing and serving food. Cook D stated, "The food quality is good." Cook D denied hearing any complaints or concerns about meals. On 08/01/2023, Surveyor observed Cook D preparing and serving the noon meal. Cook D had shoulder length hair and a full beard (the beard extends to the top of Cook D's chest). Cook D was not wearing a beard net and did not have his/her hair pulled back while preparing and serving the noon meal. Cook D was wearing gloves. On 08/01/2023 at 12:45 PM, Surveyor interviewed Person I, a resident from adjacent	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 452	Continued From page 14	N 452		

facility (R-FAF). Person I asked Surveyor if kitchen staff should be wearing hair nets and beard nets. Surveyor asked Person I if s/he had any concerns about the meals (food preparation and food service). Person I indicated that other residents had expressed concerns about Cook D's beard and finding hair (beard hair) in food. Person I reported, "A few weeks ago, [Resident 1] and Person J (R-FAF) found hair in their food around lunch time." Person I reported, "The cook does not wear a beard net or hair net when s/he works in the kitchen."

On 08/01/2023 at 3:30 PM, Surveyor interviewed Caregiver E. Caregiver E was hired on 06/23/2023 and worked second shift. Caregiver E indicated, "About two weeks ago, some staff complained about finding hair in residents' food." Surveyor asked Caregiver E, "Did staff report finding the hair in food to management?" Caregiver E indicated that s/he believed staff reported the concern to management and Caregiver E was told the hair found in residents' food was beard hair from [Cook D].

On 08/02/2023 at 5:15 PM, Surveyor interviewed Caregiver F. Caregiver F had worked at the facility since November 2022. Caregiver F worked on first and second shifts. Caregiver F reported, "During a staff meeting (some time ago), [Regional Nurse (RN) C] told [Cook D] that s/he could not work in the kitchen without wearing a beard net or without shaving his/her beard." Caregiver F indicated that Cook D worked in the kitchen, and s/he does not wear a beard net or a hair net. Caregiver F reported about two weeks ago, Caregiver F found hair in Resident 1's food during the noon meal. Caregiver F indicated s/he informed Cook D about the hair and asked Cook D to prepare another plate for Resident 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 452	Continued From page 15	N 452		

Caregiver F indicated, "When I told [Cook D] that I found a hair in Resident 1's food, [Cook D] responded, 'I showered.'" Caregiver F indicated hair was also found in Person J's (R-FAF) around the same time. Caregiver F reiterated, "During a staff meeting, [RN C] told [Cook D] that [Cook D] needed to either shave or trim his/her beard or wear a beard net in the kitchen.

On 08/03/2023 at 11:40 AM, Surveyor interviewed Caregiver G. Caregiver G reported s/he had worked at the facility for about six months. Caregiver G usually worked the overnight (NOC) shift, but sometimes worked 12 hour shifts and started work at 6:00 PM. Caregiver G reported that s/he had found hair in residents' food during dinner meals. Caregiver G stated, "I know what hair looks like, it was beard hair." Caregiver G informed Surveyor that during a staff meeting a few months ago, management told [Cook D], if [Cook D] worked in the kitchen, s/he would need to shave (trim) his/her beard or wear a beard net.

On 08/08/2023 at 10:00 AM, Surveyor interviewed Director A. Director A reported that there is a monthly staff meeting that staff are required to attend. Director A indicated that during a staff meeting in April 2023, management reviewed their dress code. During the April 2023 staff meeting, Director A informed Surveyor that Director A reminded staff about the dress code expectations (including the expectation for male staff with facial hair to keep beards neatly trimmed). Director A told male staff that facial hair (beards) needed to be trimmed and neatly kept. Director A told Surveyor Cook D attended the April 2023 staff meeting. Director A informed Surveyor Cook D was promoted to a kitchen lead position in July 2023. Director A denied hearing any concerns or problems from residents or staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 452	Continued From page 16 about hair being found in residents' food. Director A reported that on 08/07/2023, Cook D was instructed by Regional Head of Dietary (RHD) H to wear a beard net while working in the kitchen. According to Director A, RHD H dropped off beard nets, a kitchen coat, and gloves for Cook D. On 08/08/2023 at 12:40 PM, Surveyor interviewed RN C. Surveyor asked RN C if s/he ever had a conversation with Cook D about wearing a beard net in the kitchen. RN C indicated that s/he spoke to Cook D about two months ago about whether Cook D would need to shave and/or trim his/her beard when wearing a N95 mask during outbreaks or periods of quarantine. RN C informed Surveyor RN C did not have a conversation with Cook D about wearing a beard net in the kitchen. RN C informed Surveyor, "The expectation for male staff is to have beards neatly trimmed whether working on the floor or in the kitchen.	N 452		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by:	N 535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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 535	Continued From page 17 Based on record review and interview, the provider did not conduct smoke detector tests once every other month in 2021 and 2022. Findings include: The facility serves up to 10 residents in the client groups of advanced aged, physically disabled, terminally ill, irreversible dementia and Alzheimer's disease. On 08/01/2023, Surveyor reviewed the provider's documentation of smoke detector tests for 2021 and 2022. There were no documented smoke detector tests in 2021 and 2022. On 08/08/2023 at 10:00 AM, Surveyor interviewed Director A. Surveyor asked Director A if the facility conducted smoke detector tests (every other month) and documented them for 2021 and 2022. Director A stated that s/he knows the facility did not conduct and/or document smoke detector tests thus far in 2023 and s/he would look to see if smoke detector tests were conducted in 2021 and 2022. On 08/08/2023 at 1:45 PM, Director A verified s/he could not find documented smoke detector tests (every other month) for 2021 and 2022.	N 535		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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
Y3234	Continued From page 18 and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, between May 2023 and June 2023, the provider did not ensure Resident 2 was treated with courtesy, respect, and full recognition of Resident 2's dignity and individuality as Caregiver L slapped Resident 2's hand during a meal. Findings include: On 07/11/2023, the Department received a complaint alleging caregiver abuse. The facility is licensed to serve up to 10 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's, terminally ill and physically disabled. On 08/01/2023, Director A provided Surveyor with an internal investigation, dated 07/12/2023. The provider investigated an allegation of caregiver abuse involving Resident 2 and Caregiver L. The investigation was conducted by Director A. The investigation, read, in part: "It was brought to my attention by a staff member [Caregiver N] that there was an incident that occurred between	Y3234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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
Y3234	Continued From page 19	Y3234		

the end of May beginning of June. [His/Her] statement was that [s/he] witnesses [sic] another staff member

[Caregiver L] slap another resident's hand that was trying to take food from other plates. [Caregiver N's]

statement was 'I saw [him/her] slap [his/her] hand and say no, don't touch other people's plates.' [Caregiver N]

also stated that she did not bring it to my attention or the assistant director's attention because [s/he] didn't want

to be a snitch."

According to the internal investigation, Director A noted, "In conclusion with doing this investigation, based on all the information and staff statements, it's an inconclusive investigation and wasn't abuse. All staff will be receiving education on Dementia training and how to properly deal with situations. Along with that, [Caregiver L] will be having separate education along with a probation period of 30 days on how s/he talks and interacts with other residents."

On 08/01/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/01/2021. Resident 2's diagnoses include dementia with behavioral disturbance. Resident 2's health care power of attorney (HCPOA) is activated. According to a Physician Fax, dated 12/20/2022, the provider requested a medication adjustment for Resident 1 "...due to increased behaviors, stealing food, grabbing residents, touching staff, begging for food, climbing over countertops." Resident 1's nursing notes indicated Resident 1 was "food driven" and had moments of profanity, but overall had a "pleasant demeanor." On 01/17/2023, the provider investigated an allegation of abuse and documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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
Y3234	Continued From page 20	Y3234		

investigation on an "Internal Investigation Form." According to the Internal Investigation Form, the provider began a "Resident Abuse and Oversight of Client Rights" investigation on 01/05/2023. According to the provider's investigation, "Sometime > Oct. 4th [Resident 2] had come to counter. (The staff person) was drinking something (and) placed it (down). Resident grabbed it and (the staff person) slapped the tops of his/her hands. [Resident 2] stated outright, 'Don't hurt me.' (The staff person) continued yelling - that's bad manners we don't do that." The staff person no longer works at the facility. Resident 2 had a behavioral management plan (BMP) that addresses "Grabbing at other's food on their plates."

The following interventions are noted on Resident 2's BMP:

- Show him/her that the items s/he's grabbing isn't food
- Offer him/her something to drink to redirect him/her back to the table where s/he can't grab objects
- Move him/her to a different table if s/he's grabbing at others' food
- Can redirect him/her back to his/her room, or try to get him/her to go on a walk
- Being moved from room 12 to 19 to see if behaviors decrease. HC-POA agreed
- Does have a PRN (as needed) Lorazepam

On 08/01/2023 at 11:30 AM, Surveyor interviewed Resident 2. Surveyor asked Resident 2 some general questions. Resident 2 smiled and was not able to answer Surveyor's questions in a manner that provided accurate information.

On 08/02/2023 at 1:30 P.M., Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015552	A. BUILDING: _____ B. WING _____	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE MINOCQUA II	8730 B 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
Y3234	Continued From page 21 interviewed Caregiver N. Caregiver N reported, "I don't remember the exact date, maybe in April or May 2023, I witnessed [Caregiver L] slap [Resident 2's] hand between breakfast and lunch. After multiple attempts to redirect [Resident 2], [Caregiver L] 'got frustrated' and slapped [Resident 2's] hand after [Resident 2] was trying to pick 'scraps' off other peoples' plates." Caregiver N stated, "I told management about a month ago; I should have reported it sooner. I was interviewed by [Director A] after reporting it." Caregiver N commented, "The slap was not enough to hurt [Resident 2], but got [his/her] attention." On 08/02/2023 at 5:15 PM, Surveyor interviewed Caregiver F. Surveyor asked Caregiver F if s/he had any information about the allegation of "Resident 2 being slapped by a caregiver." Caregiver F reported that s/he did not see it but was told by Caregiver N, Caregiver N saw it and reported it to management. Caregiver F informed Surveyor Resident 2 had interventions in place and "Caregiver L does not have patience."	Y3234		