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 _____	R-C 02/19/2025

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 02/18/2025, Surveyor conducted a standard licensure survey, complaint investigation and verification visit at Country Terrace Minocqua II. Data collection continued through 02/19/2025. The deficiencies identified in statement of deficiency (SOD) NB6613 were corrected. The complaint was unsubstantiated. One deficiency was identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days after law enforcement personnel was called to the facility for a welfare check on Resident 1.	N 164		

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
	0015552	A. BUILDING: _____ B. WING _____	R-C 02/19/2025

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 164	Continued From page 1 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 community based residential facility (CBRF), Country Terrace Minocqua I. The two CBRFs have a shared entrance, lounge area, dining room, and kitchen. On 11/07/2024 and 12/11/2024, the department received a complaint alleging concerns with medication administration and resident rights. On 02/18/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 08/23/2024. Resident 1 died on 11/11/2024. According to a Resident/Visitor Incident Report, date of incident: 11/09/2024, "The police arrived because the [son/daughter] had called for a welfare check and accused staff of not allowing [him/her] to speak to [his/her] [dad/mother], which is untrue." On 11/09/2024, Director A noted, "I was at home and received a phone call from my facility that the Minocqua PD (police department) were in my building because of a call from [Family Member (FM) B] for a welfare check on [his/her] [parent] [Resident 1]." On 02/19/2025, Surveyor checked Department records. There was no record of the provider reporting the 11/09/2024 law enforcement contact. On 02/19/2025 at approximately 11:51 AM, Surveyor interviewed Director A via telephone. Surveyor asked Director A about law enforcement visiting the facility on 11/09/2024. Director A	N 164		

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 _____	R-C 02/19/2025

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 164	Continued From page 2 verified that law enforcement was at the facility on 11/09/2024 for a welfare check on Resident 1. Director A reported that Director A did not report the law enforcement contact to the Department but sent the necessary paperwork to Vice President of Nursing Services (VPNS) C per the provider's self-report procedure. Director A stated that VPNS C would have been responsible for reporting the incident to the Department. Director A informed Surveyor that Director A would have to reach out to RN D about whether or not the incident was reported to the Department because VPNS C recently retired. On 02/19/2025 at approximately 3:30 PM, Surveyor interviewed Director A via telephone. Director A reported that Director A forwarded self-report information regarding law enforcement contact on 11/09/2024 to VPNS C. Director A confirmed that there was no record of VPNS C sending the self-report information to the Department. Director A indicated that Director A would look for the self report paperwork and forward to the Department when found.	N 164		