| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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<br><br>On 10/01/2024, Surveyor conducted a complaint investigation and verification visit at Country Terrace Black River Falls II. Data collection continued through 10/10/2024.<br><br>The complaint was substantiated.<br><br>Four deficiencies were identified.<br><br>Four of 4 were repeat deficiencies. See Statement of Deficiency (SOD) TUWG11, dated 03/27/2024, SOD 4V7911, dated 07/27/2022, SOD 4EIN12, dated 02/17/2021, and SOD 4EIN11, dated 11/12/2019.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 25 | {N 000} | | |
| {N 214} | 83.15(3)(a) Administrator shall supervise daily operation<br><br>The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the | {N 214} | | |

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 |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 214} | Continued From page 1 | {N 214} | | |

administrator did not supervise the daily operations, including supervision to ensure proper care and services, that the residents' health and safety were protected and promoted, and that residents' rights were respected.

This is a repeat deficiency. See Statement of Deficiency (SOD) TUWG11, dated 03/27/2024, SOD 4EIN12, dated 02/17/2021, and SOD 4EIN11, dated 11/12/2019.

Findings include:

On 08/22/2024, the department received a complaint alleging resident care needs were not being met.

The provider is licensed to serve up to 25 residents in the following client groups: advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.

On 09/30/2024, Surveyor reviewed department records and identified the following:

On 05/07/2024, the department issued a Notice and Order letter with SOD TUWG11, dated 03/27/2024. The letter stated, in part:
Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS:

Pursuant to Wis. Stat. § § 50.03(5g)(b)3. and (b)6., EFFECTIVE IMMEDIATELY, the licensee shall comply with requirements specified by Wis. Admin. Code § DHS 83.15(3)(a). That is, the licensee shall ensure the administrator supervises the daily operation of the CBRF

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 214} | Continued From page 2<br>(Community Based Residential Facility), including but not limited to, resident care and services, personnel, and physical plant. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency TUWG11.<br><br>The licensee's corrective measures shall include, at a minimum, the development (or review/revision) of written procedures to address:<br><br>Medication Management and Administration, including how the licensee will:<br>-Document medication orders, medication administration, and missed/refused doses<br>-Administer medications to ensure tenants receive medications at the intervals and dosages prescribed<br>-Obtain prescription medications and refills in a timely manner<br>-Prevent medication errors<br>-Respond to medication errors if they occur, and<br>-Monitor for adverse side effects.<br><br>On 10/01/2024, with information gathered through 10/10/2024, Surveyor conducted a verification visit and a complaint investigation resulting in 4 deficiencies. The complaint was substantiated. Four of the 4 violations were repeat violations. See SOD TUWG11, dated 03/27/2024, SOD 4EIN12, dated 02/17/2021, SOD 4V7911, dated 07/27/2022 and SOD 4EIN11, dated 11/12/2019. The deficiencies were as follows:<br><br>83.15(3)(a) Administrator Shall Supervise Daily Operation<br>83.32(3)(h) Rights Of Residents: Receive Medication<br>83.37(2)(d) Documentation Of Medication Administration | {N 214} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 214} | Continued From page 3<br>83.43(1) Environment Safe, Clean, And Comfortable<br><br>On 10/10/2024, at 11:00 AM, Surveyor interviewed Director A via phone. When asked to describe the provider's management structure, Director A stated s/he was the director and s/he did not currently have an assistant director. Director A stated s/he had shift leads for first and second shift. Director A stated the provider had a regional registered nurse, Director of Clinical Services (DCS) E. Director A identified Licensee G as the owner. When asked if Director A reviewed the special orders sent by the department, Director A stated s/he did. When asked if any revisions were made to the medication administration policy and procedure, Director A stated s/he was not aware of any revisions. Director A stated that if revisions were made, they would have been made by DCS E or someone in the corporate office. Director A stated s/he would not have been involved. Director A affirmed the primary contacts for the provider were DCS E and Licensee G. Director A stated DCS E and Licensee G would receive electronic SODs and forward them to Director A.<br><br>The provider did not ensure residents' rights, health and safety were protected by not reporting allegations of caregiver misconduct to the Department. The provider did not ensure residents received proper care and services by not ensuring that residents received their medications as prescribed. | {N 214} | | |
| {N 352} | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., | {N 352} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 352} | Continued From page 4<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Resident 10 received all medications in the dosages and at intervals prescribed by a practitioner.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) TUWG11, dated 03/24/2024, SOD 4EIN12, dated 02/17/2021 and SOD 4V7911, dated 07/27/2022.<br><br>Findings include:<br><br>On 08/22/2024, the department received a complaint alleging residents were not receiving their medications.<br><br>The provider is licensed to serve up to 25 residents in the following client groups: advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.<br><br>On 10/01/2024, at approximately 10:30 AM, Surveyor interviewed Director A about concerns related to residents not receiving medications as ordered. Director A stated s/he did the monthly Medication Administration Record (MAR) audit yesterday and noticed one of the veteran residents did not have his/her medications for a couple of days. Director A stated the physician changed and the provider was waiting on a prescription renewal. Director A stated it was a mess with the VA (Veterans Administration) and | {N 352} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 352} | Continued From page 5<br>the provider stayed on top of it the best it could. When asked about the resident referenced in the discussion, Director A stated it might have been Resident 10 but s/he would have to double check.<br><br>At approximately 12:15 PM, Surveyor reviewed Resident 10's record. Resident 10 was admitted to the facility on 03/30/2023. Resident 10 had diagnoses that included adult failure to thrive, anemia, atrial fibrillation, diabetes mellitus type 2, and chronic obstructive pulmonary disease. Resident 10 was his/her own decision maker and had medications managed by the provider.<br><br>The August 2024 MAR indicated Resident 10 was taking Docusate Senna (50/8.6 MG) 1 tablet at HS (bedtime.) On 08/10/2024 through 08/31/2024, there was a circle where staff initials were typically found. Staff notes on the back of the MAR read, in part, "8/10 Docusate Senna don't have med (medication.) VA notified pending Rx (Prescription) 8/14." The September 2024 MAR included the same Docusate Senna order. On 09/01/2024 through 09/20/2024, there was a circle where staff initials were typically found. Staff notes on the back of the MAR read, in part, "9/3 Docusate Senna don't have med ...VA notified 9/2 Senna pending."<br><br>The August 2024 MAR indicated Resident 10 was taking Sodium Chloride (1 GM) 2 tablets twice daily. On 08/13/2024 through 08/28/2024, there was a circle where staff initials were typically found. Staff notes on the back of the MAR read, "8/13 AM Sodium Chloride not available ...VA notified pending Rx 8/14."<br><br>At 2:16 PM, Surveyor interviewed Caregiver C. Caregiver C stated the provider had a hard time getting medications from the VA. Caregiver C | {N 352} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 352} | Continued From page 6 | {N 352} | | |

stated the provider would call the VA multiple times to get updates on where the medications were. Caregiver C stated s/he was aware of multiple examples of when a medication was not available to administer to residents due to the provider waiting on the medication.

At 2:46 PM, Surveyor interviewed Caregiver D. Caregiver D stated VA residents had issues getting their medications. Caregiver D stated Resident 10 did not currently have his/her Senna medication.

At approximately 3:30 PM, Surveyor interviewed Director A regarding Resident 10's medications. Director A stated Resident 10's Docusate Senna had been unavailable. Director A stated Resident 10's Sodium Chloride had been "held up" one time in August and it was not available to be administered. Director A stated Resident 10's Docusate Senna might have been discontinued or refused despite documentation stating it was not available. Director A stated s/he would follow up with Surveyor regarding the Docusate Senna by the end of the following day.

On 10/02/2024, Surveyor received an email from Director A, including the following information:

-On 07/30/2024, a staff progress note indicated Resident 10's Docusate Senna had not been given and needed to be refilled. It stated the VA was notified and was pending the prescription order.

As of 10/03/2024, Director A had not provided any further clarification on the Docusate Senna order.

On 10/10/2024, at 11:00 AM, Surveyor interviewed Director A via phone regarding

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 352} | Continued From page 7<br>resident medications. Director A stated that obtaining resident medications from the VA continued to be a concern and s/he brought the concerns to directors' meetings for discussion. Director A stated s/he considered scheduling specific days each month to contact the VA and pharmacy to review the status of medications and attempt to address any barriers. Director A stated s/he assigned his/her shift leads to provide daily oversight of the MARs and medication carts. Director A stated s/he had gotten more assertive with the pharmacy as it related to expediting needed medications.<br><br>The provider did not ensure Resident 10 received all medications in the dosages and at intervals prescribed by a practitioner. Resident 10 did not receive his/her Sodium Chloride and Docusate Senna medication as ordered. | {N 352} | | |
| {N 415} | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by: | {N 415} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 415} | Continued From page 8<br><br>Based on record review and interview, the provider did not ensure that at the time of medication administration, the person administering the medication documented in the resident record the name, dosage, date and time of medication taken, and initial the medication administration record (MAR).<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) TUWG11, dated 03/27/2024.<br><br>Findings include:<br><br>The provider is licensed to serve up to 25 residents in the following client groups: advanced aged, terminally ill, physically disabled, and irreversible dementia/Alzheimer's disease.<br><br>On 10/01/2024, Surveyor reviewed the MARs for Resident 1, Resident 3, and Resident 14.<br><br>Resident 1<br><br>Resident 1 was admitted on 08/01/2023. The MAR for July 2024 through August 2024 indicated the following medications were not charted by staff for each date:<br><br>Gabapentin 400 mg take 1 capsule at 8:00 PM<br>-07/05/2024 8:00 PM<br><br>Olanzapine 2.5 mg take 1 tablet 2 times a day at 8:00 AM and 8:00 PM<br>-07/26/2024 8:00 PM<br><br>Eliquis 5 mg take 1 tablet 2 times daily at 8:00 AM and 8:00 PM<br>-08/02/2024 8:00 PM<br>-08/03/2024 8:00 PM | {N 415} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 415} | Continued From page 9<br>Nitrofurantoin Mono-MCR take 1 capsule at 8:00 PM<br>-08/04/2024 8:00 PM<br><br>The August 2024 MAR showed the following medication order: Fluconazole 150 mg take 1 tablet once weekly on Tuesday at 8:00 AM for 6 months (End Date 7/30). Staff initials were observed on 08/06/2024, 08/13/2024, 08/20/2024 and 08/27/2024. The September 2024 MAR showed the same order with the "End Date 7/30" instruction highlighted in orange. Staff initials were observed on 09/03/2024, with subsequent dates crossed out with an "X." The medication was signed off as administered despite the order indicating the medication was to end on 07/30/2024.<br><br>Resident 3<br><br>Resident 3 was admitted on 05/08/2024. The MAR for August 2024 indicated the following medications were not charted by staff for each date:<br><br>Nystatin Powder apply topically where needed three times daily.<br>-08/29/2024 2:00 PM<br><br>Latanoprost 0.005% drops administer one drop into each eye every night.<br>-08/20/2024 8:00 PM<br><br>Resident 14<br><br>Resident 14 was admitted on 04/25/2023. The MAR for August 2024 indicated the following medication was not charted by staff for each date:<br><br>Simvastatin 20 mg take 1 tablet at 8:00 PM for | {N 415} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 415} | Continued From page 10<br>Hyperchylomicronemia.<br>-08/14/2024 8:00 PM<br><br>On 10/10/2024, at 11:00 AM, Surveyor interviewed Director A regarding medication documentation. When asked about Resident 1's Fluconazole order being signed off after it appeared to have ended, Director A stated s/he wondered if the medication passer was not paying attention and signed it off without administering to the resident. Director A stated that if the medication had ended, there likely would not have been a supply of the medication to administer. Director A stated s/he would review all resident MARs monthly. Director A stated s/he would follow up with all staff to ensure medication administration was documented accurately as s/he was aware of the requirement for documentation at the time of administration. Director A stated s/he assigned his/her shift leads to support with the task.<br><br>The provider did not ensure that at the time of medication administration, the person administering the medication documented in the resident record the name, dosage, date and time of medication taken and initial the medication administration record, when Resident 1, Resident 3 and Resident 14 had multiple medications not charted by staff. | {N 415} | | |
| {N 481} | 83.43(1) Environment safe, clean, and comfortable<br><br>Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. | {N 481} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 481} | Continued From page 11<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not provide an environment that was safe, clean, comfortable, and homelike.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) TUWG11, dated 03/27/2024.<br><br>Findings include:<br><br>On 08/22/2024, the department received a complaint alleging resident rooms smelled of urine and body odor.<br><br>On 10/01/2024, at approximately 10:30 AM, Surveyor interviewed Director A. Director A stated the provider did not have a designated housekeeper and floor staff were responsible for deep cleaning resident rooms on their shower days. Director A stated the medication passers would help with cleaning as able. When asked about recent updates in the building, Director A stated the carpet near the library had a little fraying and was next on the list to be replaced. Director A stated the provider had been updating carpeting section by section. Director A stated the library was accessible to residents but not often used by residents. Director A stated the odor in the hallway near Resident 2's room was "chronic" but improved. Director A stated the provider had struggled with Resident 2's room and would shampoo Resident 2's carpet weekly. Director A stated Resident 2 struggled with incontinence and could verbalize when s/he needed staff assistance but did not always do so. | {N 481} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 481} | Continued From page 12<br><br>At 10:57 AM, Surveyor observed the carpeting in the library area. The carpet had frayed strings in two separate sections along a rubber transition strip that separated the carpet from the vinyl flooring in the hallway. One section was approximately 10 inches long, and the other was approximately 3 inches long.<br><br>At 11:10 AM, Surveyor interviewed Resident 1 in his/her room. Surveyor asked permission to observe Resident 1's bathroom and noticed the garbage was full. The garbage had evidence of products soiled with a bowel movement and presented with strong odor. When asked how long it had been since the garbage was taken out, Resident 1 stated s/he was not sure.<br><br>At 11:32 AM, Surveyor observed Resident 10's bathroom. The toilet had a toilet riser placed on it that had yellow stains on the seat and dried stool on the inside of the riser.<br><br>At 11:34 AM, Surveyor interviewed Resident 2 in his/her room. The room smelled of urine upon entry. Resident 2 stated staff asked him/her to leave the room when they cleaned and s/he would need to be out of his/her room for half the day. Surveyor noticed small white pieces of debris on the carpet near the foot of the bed. Surveyor asked permission to observe Resident 2's bathroom and noticed splatters of stool inside the toilet bowl, brown splatters on the shower floor, on the wall above the garbage can and underneath the base of the sink. When asked how often staff cleaned his/her room, Resident 2 stated s/he would leave the room weekly so staff could clean.<br><br>At 11:42 AM, Surveyor interviewed Resident 3 in his/her room. The room smelled of urine upon | {N 481} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 481} | Continued From page 13<br><br>entry. Resident 3 stated s/he had a medical condition that caused him/her to have frequent diarrhea. Resident 3 stated s/he had accidents on his/her carpet because s/he did not always make it to the bathroom. Resident 3 stated staff had not shampooed his/her carpet since s/he moved there and would only vacuum over the soiled areas. Surveyor observed an unplugged mini refrigerator sitting directly next to Resident 3's bed. The bed was placed in a corner, allowing Resident 3 access to the bed from the left side. The refrigerator was placed on the left side of the bed near the head of the bed. Resident 3 stated it was broken and the provider was waiting for Resident 3's daughter to pick it up. Resident 3 stated it had been sitting there for about one month and s/he did not like it there. Resident 3 stated the provider told him/her they could not dispose of it for him/her.<br><br>At 12:09 PM, Surveyor observed Resident 5's room. The floor was very sticky and created a noise with every step taken. The room had an unknown odor. Resident 5's bed had not been made and the bedsheet had curled upward, exposing a portion of the mattress below. The mattress had extensive yellow stains along the right side of the bed. The stains covered approximately 3 feet in length and 12 inches wide. The end table next to the bed had dark yellow and brown stains on it. There were dark yellow and brown splatters on the floor on the left side of the bed. The bathroom toilet had brown streaks running down the outside of the toilet. The toilet seat had brown streaks on it. There was hair and unknown debris partially blocking the sink drain. The bathroom light switch had brown discoloration on it. The light switch near the room entry way had brown discoloration on it. | {N 481} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 481} | Continued From page 14<br><br>At 12:11 PM, Surveyor observed Resident 11's room. Resident 11's bathroom had a strong smell of urine. There appeared to be used and discarded gloves sitting on the floor at the base of the toilet.<br><br>At 1:54 PM, Surveyor returned to Resident 5's room. The bed had been made since the last observation. The floor was still sticky, and odor was still present.<br><br>At 1:56 PM, Surveyor interviewed Caregiver B. When asked about housekeeping tasks, Caregiver B stated the staff working the floor were responsible for cleaning. Caregiver B stated Resident 3 would have loose stools and Resident 3's room often had an odor. Caregiver B stated staff would do the best they could to manage it. Caregiver B stated s/he was not aware if Resident 3's carpet had been shampooed. Caregiver B stated Resident 2's room would often have an odor and Resident 2 was very incontinent. Caregiver B stated Resident 2 would have accidents on the carpet and the carpet was usually cleaned weekly.<br><br>At 2:46 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 3's room would often have an odor and staff could smell it. Caregiver D stated Resident 3 would change his/her own brief sometimes and not alert staff. Caregiver D stated Resident 2's room had an odor and Resident 2 had a history of denying staff assistance. When asked about housekeeping tasks, Caregiver D stated some days it was physically impossible for staff to get cleaning tasks completed. Caregiver D stated resident call lights would sometimes go off nonstop and not allow time for cleaning.<br><br>On 10/10/2024, Surveyor interviewed Director A | {N 481} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0016076 | A. BUILDING: _____ B. WING _____ | R-C 10/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE BLACK RIVER FALLS II | 642 E 3RD 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 481} | Continued From page 15<br>via phone regarding environmental concerns. Director A stated s/he would continue to provide education to staff regarding housekeeping expectations. Director A stated they were replacing the cannisters in the air filtration system to support with odor reduction. | {N 481} | | |