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 12/01/2025

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 On 11/13/2025, Surveyor conducted a verification visit and complaint survey at Country Terrace Black River Falls II. Data was collected through 12/01/2025. The complaint was substantiated. Four deficiencies were identified. Three of the 4 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) TUWG11, dated 03/27/2024; SOD TUWG12, dated 10/10/2024; and TUWG13, dated 03/03/2025. Census: 17 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview the provider did not immediately notify Resident 4's physician when Resident 4 exhibited changes in	N 169		

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

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N 169	Continued From page 1 his/her mental and physical condition. Findings include: On 08/19/2025, the department received a complaint with allegations related to medication administration and required notifications. From 11/13/2025 to 11/26/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 05/19/2025. S/he had a diagnosis of schizoaffective disorder, and s/he had a legal guardian. On 07/06/2025, staff documented: "Resident said '[s/he] gives up and doesn't want to this anymore.' Didn't want to take [his/her] meds (medications) but convinced [him/her] otherwise." On 07/08/2025, staff documented: "Resident is shaky and had a blowout - Resident didn't want to take 5p (5:00 p.m.) meds, but I assisted w/ (with) getting [him/her] to eat and take meds @ (at) 7 pm." On 07/09/2025, p.m. shift, staff documented: "Resident was very shaky, could barely walk, stayed in bed almost whole shift. Ripped shirt getting tangled in [his/her] call button. Also got lost in [his/her] room & couldn't figure out how to back up when ran into something." On 07/09/2025, NOC (overnight) shift, staff documented: "Same as PM shift also could bearly [sic] talk. [Staff] took [his/her] blood sugars & checked vitals [s/he] was getting a little out of hand so we agreed [s/he] better go [sic] hospital & get checked out. Called [his/her] [legal	N 169		

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N 169	Continued From page 2	N 169		

guardian]. [S/he] also agreed that sending [him/her] to hospital was the best way to send [him/her] to hospital [sic]."

The documentation indicated that Resident 4's legal guardian was not notified until the overnight shift on 07/09/2025 that Resident 4 was having a change in condition. There was no documentation to indicate Resident 4's physician was notified that Resident 4 was having a change in condition.

Resident 4 was hospitalized from 07/10/2025 to 08/08/2025. Documentation from the hospital, print date of 08/25/2025, read, in part: "Admit to [skilled nursing facility] 8/8/25, after acute hospitalization from 7/10-8/8/25 due to acute septic shock from CAUTI (catheter associated urinary tract infection) with lithium toxicity and AKI (acute kidney injury). Seen at [hospital] and transferred to [hospital] for additional services. Required hemodialysis x2 sessions with improvement of renal function, returning back to CKD (chronic kidney disease) stage 4 ..."

On 11/26/2025 at approximately 11:30 a.m., Surveyor interviewed Administrator A and Assistant Director (AD) B on the phone. Surveyor asked if Resident 4's legal guardian and physician were notified when Resident 4 exhibited changes in condition that staff documented on 07/06/2025, 07/08/2025, and 07/09/2025. AD B told Surveyor Resident 4's legal guardian was very involved with Resident 4 and staff communicated with him/her daily. AD B told Surveyor if staff would have notified Resident 4's physician it would be documented in Resident 4's record.

There was no documentation to indicate staff notified Resident 4's physician when s/he

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N 169	Continued From page 3 experienced a change in condition.	N 169		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document in the resident's record a medication error and adverse reaction when Resident 4 developed lithium toxicity. This is a repeat deficiency. See Statement of Deficiency TUWG11, dated 03/27/2024. Findings include: On 08/19/2025, the Department received a complaint with allegations related to medication administration. From 11/13/2025 to 11/26/2025, Surveyor reviewed Resident 4's record.	N 410		

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N 410	Continued From page 4 Resident 4 was admitted to the facility on 05/19/2025. S/he had a diagnosis of schizoaffective disorder. Resident 4's admission orders indicated Resident 4 was prescribed: lithium carbonate extended release (ER) 300 milligrams (mg). Take 1 tablet, by mouth, in the morning, and 1 tablet in the evening. A prescription, dated 06/20/2025, indicated a physician prescribed Resident 4 lithium carbonate 300 mg, take 2 capsules at bedtime. This order was not for an extended release tablet. Resident 4's medication administration record (MAR) for June and July 2025 were not clear on how much lithium Resident 4 received. On 07/09/2025 on the PM (evening) shift staff documented: "Resident was very shaky, could barely walk, stayed in bed almost whole shift ripped shirt getting tangled in [his/her] call button. Also got lost in [his/her] room & couldn't figure out how to back up when ran into something." On 07/09/2025, on the NOC (overnight) shift staff documented: "Same as PM also could bearly [sic] talk [staff] took [his/her] sugars & checked vitals [s/he] was getting a little out of hand. So we agreed [s/he] better go [sic] hospital & get checked out ..." Hospital notes for Resident 4, with a print date of 08/25/2025, read, in part: "According to history and physical from 8/10/2025: [Resident 4] was just discharged from the hospital on 8/08/2025, 2 days prior to arrival. [S/he] had been in the hospital from 7/10 through 8/08. The previous	N 410		

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N 410	Continued From page 5 admission was a transfer from [hospital] due to urosepsis with shock ... But then [s/he] continued to develop more and more agitated delirium. It was found out that [his/her] lithium level was elevated. Ultimately, it was determined that [s/he] was inadvertently receiving double doses of lithium from what was intended for [his/her] schizoaffective disorder. Later in that admission, [s/he] developed nephrogenic diabetes insipidus, also thought to be secondary to lithium ..." "Lithium toxicity (overdose) happens when you have too much of the prescription medication lithium in your body. It causes intestinal symptoms (like vomiting and diarrhea) and neurological symptoms (like confusion and uncontrolled shaking). If you don't receive treatment for lithium toxicity, it can be fatal. Lithium is a natural salt that reduces the symptoms of mania. Healthcare providers mainly prescribe it for bipolar disorder. The medication has a narrow range of safety, so it doesn't take much to have too much lithium in your body." (Retrieved on 11/26/2025 from: https://my.clevelandclinic.org/health/diseases/25207-lithium-toxicity). On 11/26/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A on the phone. Surveyor asked if they had documentation of Resident 4 receiving too much lithium and lithium toxicity. Administrator A told Surveyor they have looked for the documentation and reached out to the previous administrator and have not been able to locate this documentation. The provider did not document in Resident 4's record when s/he received too much lithium and developed and adverse reaction of lithium toxicity.	N 410		

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N 410	Continued From page 6 Cross Reference N0415 DHS 83.37(2)(d) Documentation Of Medication Administration	N 410		
{N 415}	83.37(2)(d) Documentation of medication administration. 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was accurate documentation of Resident 4's lithium carbonate dosage, date, and time. Resident 4 developed lithium toxicity. This deficiency is being cited for the fourth time. See Statement of Deficiency (SOD) TUWG11, dated 03/27/2024; SOD TUWG12, dated 10/10/2024; and TUWG13, dated 03/03/2025. Findings include: On 08/19/2025, the department received a complaint with allegations related to medication administration.	{N 415}		

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{N 415}	Continued From page 7 From 11/13/2025 to 11/26/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 05/19/2025. S/he had a diagnosis of schizoaffective disorder. Resident 4's discharge orders from the hospital, dated 05/19/2025, indicated Resident 4 was prescribed: lithium carbonate extended release (ER) 300 milligrams (mg). Take 1 tablet, by mouth, in the morning, and 1 tablet in the evening. Resident 4's medication administration record (MAR) for June 2025 included a typed order that read: Lithium carbonate ER 300 Take one tablet by mouth 2 times a day at 8:00 a.m. and 5:00 p.m. The 5 in 5:00 p.m. had an 8 handwritten over it and a note handwritten on the bottom, which read: "Take 2 @ 8 pm" It was not dated as to when the handwritten changes were made to the MAR. On 06/19/2025 the 8:00 a.m. dose was initialed and circled. On the back of the MAR for 06/19/2025 it indicated all AM medications were "NA" (not available). On 06/20/2025, the medication was initialed as administered at 8:00 a.m. and 5:00 p.m. From 06/21/2025 to 06/30/2025, the 8:00 a.m. medication doses were initialed and circled. The back of the MAR indicated the morning doses of lithium were not available on the following dates: 06/21/2025, 06/23/2025, 06/24/2025, 06/26/2025, 06/28/2025, and 06/29/2025. There was no documentation to indicate why the morning dose	{N 415}		

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{N 415}	Continued From page 8 of lithium was initialed and circled on the following dates: 06/22/2025, 06/25/2025, 06/27/2025, and 06/30/2025. On 06/21/2025, the 5:00 p.m. dose of lithium was initialed and circled. On the back of the MAR it indicated the 5:00 p.m. dose of lithium was not available. From 06/22/2025 - 06/27/2025, there was no staff documentation on the MAR for the 5:00 p.m. dose of lithium. The squares were blank for those dates and time. From 06/29/2025 - 06/30/2025, staff initialed and circled the 5:00 p.m. doses of lithium. On the back of the MAR, on 06/28/2025, 06/29/2025, and 06/30/2025 staff wrote the lithium was not available. Staff drew lines through this documentation for the PM dose of lithium on the 06/28/2025 and 06/29/2025 doses. From 06/21/2025 to 06/30/2025, the MAR indicated staff administered lithium 2 tablets at 8:00 p.m. Resident 4's MAR for July 2025, was separated into specific times for each medication. There was an order to give Resident 4 lithium carbonate 300 mg ER at 8:00 a.m. and 5:00 p.m. There was a second order to give lithium carbonate 300 mg take 2 capsules by mouth at 8:00 p.m. The 8:00 p.m. order was not for an extended release tablet. The 8:00 a.m. dose of lithium carbonate 300 mg ER was initialed and circled for 07/01/2025, 07/02/2025, and 07/03/2025. The back of the MAR indicated the medication was not available on 07/01/2025 and 07/03/2025 for the 8:00 a.m. doses. There was no documentation to indicate	{N 415}		

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{N 415}	Continued From page 9 why the 8:00 a.m. dose on 07/02/2025 was initialed and circled. The 8:00 a.m. doses of lithium 300 mg ER were initialed as administered from 07/04/2025 to 07/09/2025. The 5:00 p.m. dose of lithium carbonate 300 mg ER was initialed as given on 07/01/2025. The 5:00 p.m. dose for lithium carbonate 300 mg ER was initialed and circled on 07/02/2025 and 07/03/2025. On the back of the MAR staff documented for 07/02/2025 and 07/03/2025 5:00 p.m.: "only bedtime dose." The 5:00 p.m. doses for lithium carbonate 300 mg ER were documented as administered on 07/04/2025 to 07/08/2025. The 8:00 p.m. doses of lithium carbonate 300 mg (not ER) were documented as administered from 07/01/2025 to 07/09/2025. There was no staff documentation to indicate staff notified the provider when a medication was not available for an extended amount of time. Hospital notes for Resident 4, with a print date of 08/25/2025, read, in part: "According to history and physical from 8/10/2025: [Resident 4] was just discharged from the hospital on 8/08/2025, 2 days prior to arrival. [S/he] had been in the hospital from 7/10 through 8/08. The previous admission was a transfer from [hospital] due to urosepsis with shock ... But then [s/he] continued to develop more and more agitated delirium. It was found out that [his/her] lithium level was elevated. Ultimately, it was determined that [s/he] was inadvertently receiving double doses of lithium from what was intended for [his/her] schizoaffective disorder. Later in that admission, [s/he] developed nephrogenic diabetes insipidus, also thought to be secondary to lithium ..."	{N 415}		

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{N 415}	Continued From page 10 Documentation from the hospital indicated Resident 4 required 2 sessions of hemodialysis. On 11/26/2025 at approximately 11:00 a.m., Surveyor interviewed Administrator A and Assistant Director (AD) B on the phone. Surveyor asked how much lithium Resident 4 received from 06/19/2025 to 07/09/2025. Administrator A said a different physician was filling in for Resident 4's primary care provider and the other physician wrote the order for lithium carbonate 300 mg 2 tablets at 8:00 p.m., that was not an extended release tablet. Surveyor asked who was responsible for documenting on the MAR when a medication order changes. Administrator A said it would typically be the director but any staff who received medication training could enter that information into the MAR. The second order of lithium was not an extended release and would then not be the same as the order that was changed on the June 2025 MAR. Administrator A told Surveyor s/he agreed. Surveyor explained if staff would have called and notified Resident 4's primary care provider that the other order of lithium was not available, they may have been able to determine that there were 2 separate orders for lithium. AD B told Surveyor that staff were to document in the record when notifying the physician. AD B told Surveyor the physician should be notified when a resident missed a "couple doses" of their medication. Surveyor and Administrator A were unable to determine how much lithium Resident 4 received as staff documentation was not clear on the MARs. The provider did not ensure there was accurate documentation of Resident 4's lithium carbonate dosage, date, and time. Resident 4 developed lithium toxicity.	{N 415}		

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{N 427}	Continued From page 11	{N 427}		
{N 427}	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. This is a repeat deficiency. See Statement of Deficiency TUWG13, dated 03/03/2025. Findings include: The provider is licensed to care for up to 25 residents in the client groups of: irreversible dementia/Alzheimer's disease, advanced age, terminally ill, and physically disabled. On 11/13/2025 at approximately 10:15 a.m., Surveyor interviewed Assistant Director (AD) B. AD B told Surveyor the activity director was a high school student and s/he quit last week. S/he said	{N 427}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 427}	Continued From page 12 the caregivers will do activities when they have time but somedays were "hectic" and there was not enough time. S/he said the residents did enjoy playing bingo and doing crafts. On 11/13/2025 at approximately 10:40 a.m., Surveyor interviewed Resident 1, Resident 2, and Resident 3. The 3 residents were sitting together at the dining room table. Surveyor asked if they did any group activities. Resident 1 said, "We used to, but we just sit here now." Surveyor asked if the caregivers did activities with them. Resident 1 told Surveyor they do not have time. Resident 2 told Surveyor the previous director's son/daughter would come in and do bingo, but s/he was back to school and did not come too much. On 11/13/2025 at approximately 10:55 a.m., Surveyor interviewed Caregiver C. Caregiver C told Surveyor they used to have an activity person who came in on Mondays, Wednesdays, and Fridays. Surveyor asked what residents did on the days the activity person was not there. Caregiver C said the residents would "do their own thing." Caregiver C told Surveyor, "Sometimes" the caregivers have time to play cards with the residents. On 11/13/2025, Surveyor reviewed the activity calendars from July 2025 - November 2025. The July 2025 activity calendar indicated there was bingo on Mondays, Wednesdays, and Fridays. There were no specific times or dates on the calendar. On 3 Tuesdays, there was an activity and on 2 Thursdays, there was an activity. There were no planned activities for Saturdays or Sundays.	{N 427}		

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 12/01/2025

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 427}	Continued From page 13 The August 2025 activity calendar indicated there was bingo on Mondays, Wednesdays, and Fridays. There was a movie and craft on the first Tuesday. There was a movie and craft on the 2nd and 3rd Thursday. There were no other activities documented on the calendar. The calendar did not identify the date or the time. The September 2025 activity calendar indicated there was bingo on Mondays, Wednesdays, and Fridays. The 2nd week in September indicated it was National Assisted Living Week and there was an activity planned for each day Monday - Friday. The 4th Tuesday there was movie and craft. The calendar did not identify the date or the time. There were no planned activities for Saturdays or Sundays. The October 2025 activity calendar did have dates. The calendar indicated there was bingo on Mondays, Wednesdays, and Fridays, with the exception of Halloween documented as the activity for 10/31/2025. On 10/07/2025 and 10/09/2025, a movie was documented as the activity. On 10/14/2025, a bible service TV was documented as the activity. There were no times documented for the planned activity. The other dates in October did not have an activity documented. The November 2025 activity calendar did not indicate a planned activity for the following dates: 11/01/2025, 11/02/2025, 11/06/2025, 11/09/2025, 11/15/2025, 11/16/2025, 11/20/2025, 11/22/2025, 11/23/2025, 11/24/2025, 11/27/2025 and 11/29/2025. The provider did not provide a daily activity program to meet the interests and capabilities of the residents.	{N 427}		

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 12/01/2025

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

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