STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015628	A. BUILDING: _____ B. WING _____	C 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN TERRACE SENIOR LIVING CBRF	3402 TERRACE CT WAUSAU, WI 54401

(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 08/22/2025 to 08/29/2025, Surveyor conducted 3 complaint investigations and a standard survey at Mountain Terrace Senior Living CBRF. Two deficiencies were identified. Two complaints were unsubstantiated. One complaint was substantiated. Census: 34	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 record review and interview, the provider did not ensure that Resident 2 received his/her medications as prescribed by his/her practitioner. From 05/01/2025-08/21/2025, staff administered Resident 2's Midodrine on 4 occurrences even though his/her blood pressure fell within parameters to hold the medication. Findings include: On 08/22/2025, Surveyor reviewed Resident 2's record and identified the following:	N 352		

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

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N 352	Continued From page 1 Resident 2 was admitted to the provider on 01/27/2025, with diagnoses including Parkinson's disease and orthostatic hypotension. Resident 2's most recent individual service plan (ISP), dated 02/04/2025, indicated staff administer his/her medications. Resident 2's physician orders included "Midodrine 5mg tablet with instructions to take by mouth 3 times a day for low blood pressure. Give with meals. Hold if top (systolic) is greater than 100, with a start date of 01/30/2025." Resident 2's medication administration record (MAR), from 05/01/2025-08/21/2025, documented the following: -05/19/2025 (evening administration): Blood pressure documented as 121/69, Midodrine administered -06/08/2025 (evening administration): Blood pressure documented as 146/106, Midodrine administered -07/01/2025 (evening administration): Blood pressure documented as 157/106, Midodrine administered -08/11/2025 (noon administration): Blood pressure documented as 101/75, Midodrine administered On 08/28/2025 at 11:45 AM, Surveyor conducted an exit conference and shared findings with Administrator A and Clinical Director B. Both acknowledged an understanding of the concern. Surveyor asked for clarification of documentation of Resident 2's blood pressure prior to administration of the Midodrine, as Resident 2's MAR did not contain all recordings. Clinical Director B stated the MAR may not allow input of the blood pressure if a staff member selects a "hold" code and instead they document in the progress notes.	N 352		

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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 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, the provider did not ensure Resident 1 was treated with courtesy, respect and full recognition of the resident's dignity and individuality. On 07/25/2025, in the process of Resident 1 being sent to the hospital, Activity Director C engaged in unprofessional conduct and made undignified comments towards Resident 1. Findings include: On 07/28/2025, the Department received a complaint alleging concerns with a resident transport to the hospital. On 08/22/2025, Surveyor conducted a complaint	Y3234		

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Y3234	Continued From page 3 investigation and identified the following: On 08/22/2025 at 10:00 AM, Surveyor interviewed Administrator A regarding the alleged incident on 07/25/2025. Surveyor asked who the employee was. Administrator A stated Activity Director C and Resident 1 were close, but s/he was unaware of any concerns. Administrator A stated s/he would be starting an investigation today. On 08/22/2025 at 10:20 AM, Surveyor interviewed Activity Director C regarding the alleged incident on 07/25/2025. Activity Director C reported that on 07/25/2025, s/he was outside in the front of the facility trying to convince Resident 1 to go to the hospital as his/her physician requested s/he be sent out. Activity Director C reported Resident 1 Asked, "Can I watch the nurses' [expletive] like I watch yours?" Activity Director C reported s/he said, "Why not." Activity Director C reported that's how Resident 1 and s/he talked to each other. Activity Director C reported s/he knew Resident 1 prior to working at the facility, so they had a friendly relationship. Activity Director C reported s/he and Resident 1 had an ongoing joke that Resident 1 was his/her work husband/wife. Activity Director C further stated Resident 1 made comments such as "S/he hates when I go, but s/he loves to watch me leave." Activity Director C stated Resident 1 was his/her own person. Surveyor asked if s/he lit a cigarette and blew smoke in EMS (emergency medical services) staff's face. Activity Director C confirmed s/he lit a cigarette while trying to convince Resident 1 to go to the hospital but denied blowing smoke at EMS staff. Activity Director C reported s/he kissed Resident 1 on the cheek in hopes s/he would go to the hospital. Surveyor asked about the allegation, Activity	Y3234		

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Y3234	Continued From page 4 Director C said s/he shook his/her butt in Resident 1's face. Activity Director C stated s/he jumped up and down because Resident 1's favorite song was jump around. Activity Director C reported s/he liked to come down to the residents' level, that they may be older and lonely, so instead of telling him/her to stop, s/he would brush off his/her comments or say something funny back. Activity Director C acknowledged the above conduct if observed from outside providers could be unprofessional, but that's how they talked and that was their thing. Activity Director C denied being investigated by the provider and this was the first time hearing about any concerns. On 08/22/2025 at 12:15 PM, Surveyor interviewed Caregiver D regarding the incident between Resident 1 and Activity Director C on 07/25/2025. Caregiver D reported s/he worked on 7/25/2025, during the alleged incident, but did not observe any unprofessional conduct. Caregiver D reported that when Activity Director C came back into the facility, s/he made a comment that s/he had to kiss Resident 1 to get him/her to go the hospital. Caregiver D reported s/he had never seen anything physical, but heard Activity Director C make comments regarding Resident 1 being his/her work husband/wife. On 08/22/2025 at 12:30 PM, Surveyor interviewed Caregiver E regarding the incident between Resident 1 and Activity Director C on 07/25/2025. Caregiver E reported s/he did not work on 7/25/2025. Caregiver E reported s/he had never seen anything physical between the two but heard Activity Director C make comments that Resident 1 was his/her work husband/wife. Caregiver E stated, "The vibe between the two was just weird."	Y3234		

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Y3234	Continued From page 5 On 08/22/2025, Surveyor reviewed Resident 1's and Activity Director C's record and found the following: Resident 1 was admitted to the facility on 05/08/2024. Resident 1 discharged from the provider on 08/12/2025. Resident 1 was his/her own decision-maker. Resident 1's progress notes documented: "07/28/2025: On 07/25/25 at 1345, Apsirus at home nurse requested staff to send resident to hospital due to low o2 stats. Resident stated [s/he] felt like [s/he] had a cold, runny nose, cough. Resident was sent to Aspirus Wausau Hospital." Resident 1's record did not contain any information regarding unprofessional conduct between Resident 1 and Activity Director C. Activity Director C was hired on 05/01/2023. Activity Director C's record documented the following training as being completed: 05/03/2024: Protecting Resident Rights in Assisted Living Facilities 02/20/2025: Compliance and Code of Conduct The employee handbook documented: "VI. Employee Conduct A. Resident and Patient Relations We are a service business and all of us must remember that it is the patient and resident who pays all of our wages. Therefore, while the resident and patient may not always be right, we should always listen to them. Our residents and patients have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, neglect, and involuntary seclusion. All employees must immediately report any incident or suspected incident of resident or patient abuse, including injuries of an unknown source and	Y3234		

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Y3234	Continued From page 6	Y3234		

misappropriation of resident or patient property to the Wellness Director, Director of Clinical Services, or the Executive Director. They are responsible for following our obligations as a mandated reporter. There is never any justification for failing to timely report suspected abuse.
If, for any reason, you do not feel comfortable reporting abuse to the individuals named above or if you feel that an incident of alleged abuse has not been addressed even after you reported it, you may call our Compliance Hotline ... which is available 24 hours a day, 7 days a week, 365 days a year. You may submit your concern online at: https://pennantservices.ethicspoint.com. Concerns may be raised anonymously, or you may give your name. Either way, the issue will be treated in as confidential a manner as possible under the circumstances.
Patients and residents are to be treated courteously and given proper attention at all times. Never regard a resident's or patient's question or requests as an interruption or annoyance. Resident, patient, and family member inquiries - whether in person or by telephone - must be addressed promptly and professionally.
I. Employee Conduct and Discipline
To ensure orderly operations and provide the best possible work environment, the Company expects Employees to follow rules of conduct that will protect the interests and safety of all Employees and the Company. It is not possible to list all forms of behavior that may be considered unacceptable in the workplace, but the following are examples of unacceptable conduct that may result in disciplinary action up to and including employment termination.
"Engaging in unethical conduct or conduct which creates a conflict of interest (as defined in the Company's Conflict of Interest policy);

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Y3234	Continued From page 7 EMPLOYEE HANDBOOK 7 Effective January 1, 2025 In its sole discretion, the Company reserves the right to determine whether an Employee's behavior is unacceptable and whether and what disciplinary action is necessary under a given circumstance. Employees may be subject to disciplinary action for poor performance or for violation of other policies and procedures not listed here." On 08/28/2025, Surveyor reviewed the provider's investigation into the alleged incident between Activity Director C and Resident 1. The following written statements were completed by staff: -"[Caregiver D]: I did not witness the incident happen but did hear about it. [Activity Director C] told me the only way to get [Resident 1] to go to the hospital was to give [him/her] a kiss." -"[Activity Director C]: I [Activity Director C] knew [Resident 1] from the bar [s/he] used to frequent that my parents went to as well as from [him/her] being friends with my significant other. On the day in question I [Activity Director C] has spoken within [sic] [him/her] about going to the hospital and [s/he] was unsure about doing so, and [s/he] asked me 'can I watch the nurses [expletive] like I watch yours' I has [sic] replies 'why not' and we had laughed about it as we had many times in the past. I kissed [him/her] on the cheek as [s/he] left and told [him/her] I would visit ASAP (as soon as possible). I was also accused of jumping up and down which is a stand [sic] joke between me and [Resident 1] due to [his/her] favorite song being 'jump around' [sic] so we always joked that I jumped for [him/her], [sic] this was a standard joke that was ongoing prior to this day. I was also accused of making the joke of [him/her] being my	Y3234		

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Y3234	Continued From page 8 'work [husband/wife]' [sic] a joke that had been on going [sic] especially since [s/he] knows my significant other .....I was also quoted of telling [him/her] 'don't make me call [mom/dad]' meaning [his/her] [mom/dad] which I did say because I felt if I couldn't get [him/her] to go to the hospital [s/he] would. I did get accused of lighting a cigarette while outside and 'blowing smoke in EMS face' [sic] I did step back and light a cigarette and turn around to find one there but I did NOT blow smoke in anyone's face which I did repeat and deny to the state personnel .... From my perspective: That day I convinced [him/her] to go by acting and laughing and joking they [sic] way we normally would have ....I feel I made mistakes and that I wanted to meet residents where they are now and understand that they are old and lonely and sometimes they cross lines and a joke or a [sic] off handed comment might make them laugh and get close to them as people and see them as people [sic] not just numbers [sic] but I also feel that considering how my attempt to do that didn't work out as for want of a better term blew up in my face that I need to achieve more professional distance going forward." On 08/28/2025 at 11:45 AM, Surveyor conducted an exit conference and shared findings with Administrator A and Clinical Director B. Surveyor reviewed the provider's investigation, employee handbook, and interviews that were conflicting with resident rights. Administrator A acknowledged Activity Director C's written statement and interviews confirmed s/he engaged in unprofessional conduct and made undignified comments towards Resident 1. Administrator A noted retraining on boundaries would occur with Activity Director C.	Y3234		

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Y3234	Continued From page 9 On 08/29/2025 at 2:50 PM, Surveyor interviewed EMS Staff A. EMS Staff A reported s/he responded to the facility on 07/25/2025, to transport Resident 1 to the hospital. EMS Staff A reported Resident 1 was reluctant to go, so s/he ran inside the facility to talk with the staff member who called. EMS Staff A reported that while inside, Activity Director C had exited the building. EMS Staff A noted his/her 2 other coworkers stood beside the stretcher and observed Activity Director C put his/her arms up in the air stating, "You are going to the hospital" and making unprofessional comments when Resident 1 asked what the hospital would even do for him/her if s/he were to be transported. Activity Director C made comments such as "You can go there and stare at a nurses' [expletive] for a few hours." EMS Staff A reported that when s/he came out and rejoined the crew and told Resident 1 his/her primary would like him/her to be transported, Activity Director C lit a cigarette and blew smoke in EMS crew members' faces. EMS Staff A reported that after some time, Resident 1 agreed to go, and Activity Director C kissed Resident 1 on the face near his/her lips while EMS was trying to secure the patient onto the stretcher. EMS Staff A reported Activity Director C proceeded to shake his/her butt in Resident 1's face and stated, "Maybe this will convince you to go." EMS Staff A stated that due to Activity Director C's proximity and his/her actions, EMS staff had to step back from the stretcher to avoid being bumped into. EMS Staff A noted that while Activity Director C was walking back into the building, s/he stated, "Bye sweetie, love you." On 08/29/2025, Surveyor reviewed the EMS report, dated 07/25/2025. The document confirmed Resident 1 was transported to the hospital.	Y3234		

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