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 _____	R-C 12/10/2025

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 12/04/2025. Surveyor conducted 3 complaint investigations and a verification visit at Mountain Terrace Senior Living CBRF. Data was collected through 12/10/2025. Three of 3 complaints were substantiated. Five deficiencies were identified. Two of 5 deficiencies were repeat deficiencies. See Statement of Deficiencies (SOD) V2PA11, dated 08/29/2025, and SOD IVLX11, dated 07/01/2021. Census: 33 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by:	N 326		

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

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N 326	Continued From page 1 Based on record review and interview, the licensee did not give the resident or resident's legal representative a 30 day written advance notice of discharge for 2 of 2 (Resident 1 and Resident 2) discharged residents reviewed. Findings include: On 11/26/2025, the Department received a complaint alleging the provider did not give a written 30 day notice when they discharged a resident. RESIDENT 1 On 12/04/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/27/2025. S/he had multiple diagnoses including: Parkinson's disease, hypertension, orthostatic hypotension, difficulty in walking, and reduced mobility. Family Member (FM) C was Resident 1's legal representative. Resident 1's date of discharge was 11/05/2025. On 10/26/2025, staff documented a monthly wellness note, which read: "There have been no changes to resident's ADLs (activities of daily living) or care needs in the past month." On 10/30/2025, documentation indicated Resident 1 became unresponsive when a caregiver was transferring him/her. The documentation read, in part: "Resident has a history of blood pressure changes that affect [him/her] while making position changes." Resident 1 was sent to the emergency room. On 11/04/2025, Clinical Director (CD) B documented: "Resident was admitted to hospital	N 326		

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for blood pressure monitoring ... Will be working on adjusting medications and doing strengthening and therapy."

On 11/06/2025, CD B documented, in part: "Resident will not be returning to Mountain Terrace due to needing more medical nursing care with B/P (blood pressure). Resident currently at [hospital]."

On 12/04/2025 at approximately 12:45 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Resident 1 was discharged due to medications and blood pressure parameters. S/he stated Resident 1 required a higher level of care. Administrator A told Surveyor Resident 1 and his/her legal representative were not given a written 30-day discharge notice. Administrator A said s/he was aware Resident 1's legal representative did want Resident 1 to return to the facility.

On 12/04/2025, Surveyor reviewed an email from Administrator A to Resident 1's managed care organization (MCO) team. The email, dated 11/05/2025, read, in part: "I think at this time we should look at transitioning [him/her] to long term nursing. I am not comfortable with the amount of nursing services [s/he] requires with [his/her] B/P medication. Our staff our [sic] not clinical ... and only have so much knowledge on medical needs for residents. They are not even able to take a manual B/P also, with [his/her] decline and needing a two person assist ..."

On 12/08/2025 at approximately 2:00 p.m., Surveyor interviewed FM C on the phone. FM C told Surveyor s/he was informed by Resident 1's case manager, from Resident 1's MCO, that the provider was not going to let Resident 1 return to

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their facility because of his/her blood pressure concerns. FM C said Administrator A or CD B did not speak to FM C about the discharge. FM C said s/he never got a 30-day written discharge notice. FM C said Resident 1 did not have any significant changes in his needs and abilities. S/he said Resident 1 was more mobile at time of discharge than s/he was when s/he first admitted. FM C said staff have always had to monitor Resident 1's blood pressure since s/he was admitted.

RESIDENT 2
On 12/04/2025, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 05/08/2024. S/he had multiple diagnoses including: chronic atrial fibrillation, congestive heart failure, hemiplegia and hemiparesis affecting left non-dominant side, and acquired absence of left leg above knee. Resident 2 did not have a legal representative and was able to make his/her own decisions. Resident 2's date of discharge was 08/12/2025.

On 07/20/2025, staff documented a monthly wellness note, which read: "There have been no changes to resident's ADLs or care needs in the past month ..."

On 07/28/2025, CD B documented: "On 7/25/25 at 1345 (1:45 p.m.) [name] at home nurse requested staff to send resident to hospital due to low o2 (oxygen) stats (saturations) ... Resident was admitted to [hospital] for CHF (congestive heart failure) exacerbation."

On 07/29/2025, CD B documented Resident 2 returned from the hospital at 6:00 p.m.

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N 326	Continued From page 4 On 07/30/2025, staff documented: "On 07/29/2025 at 21:30 (9:30 p.m.) Resident was sent out due to low oxygen ... Resident was coughing and vomited in the main area. Difficulty of breathing and O2 was 82% and was transported to the ER (emergency room) ..." On 07/31/2025, CD B documented Resident 2 was admitted to the hospital. On 08/12/2025, CD B documented: "Resident discharged from MTN (Mountain) CBRF on 8/12/25. Resident is currently at [hospital]." On 12/04/2025 at approximately 12:45 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor Resident 2's cares were increased, and s/he was discharged. Administrator A said Resident 2 did express that s/he wanted to return to the facility. Administrator A told Surveyor Resident 2 was not issued a written 30-day discharge notice. On 12/04/2025, Surveyor reviewed emails between Administrator A to Resident 2's case manager, Person D. There were no dates on the printed emails other than the printed date of 12/04/2025. An email from Administrator A to Person D read, in part: "I was told by the hospital [s/he] transitioned to [skilled nursing facility] on Friday 8/8/25. Unfortunately, due to the bed hold only lasting until 7/31/25 (auth department clarified for us), we will need to transition [him/her] out of Mountain Terrace. We do have a waiting list right now in the CBRF so we cannot hold the room for [him/her]. In my opinion with [his/her] new health concerns/wound care ... [s/he] is needing more	N 326		

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skilled nursing than what we can provide at the CBRF level."

Another email from Administrator A to Person D read, "Since [Resident 2] will not be returning to mountain terrace [sic] and we are not getting any payment/bed hold payments [his/her] items need to be removed by the end of the week. I spoke to [his/her] [mom/dad] yesterday [s/he] wasn't understanding and less helpful on what to do with [his/her] items. Can you please help address this situation and get [his/her] items removed."

An email from Person D to Administrator A read, in part: "I did speak with [name] yesterday and [s/he] is aware to get the items out by the end of the week. [S/he] was frustrated by this as [s/he] is having a hard time understanding why [s/he] could not return after [his/her] rehab. I did my best to explain that if [Resident 2] wishes, after rehab we will be pursuing other placement. I can follow up with [him/her] again today to see if [s/he] is able to make arrangements with [his/her] children to get [his/her] items out of the facility."

On 12/08/2025 at approximately 3:00 p.m., Surveyor interviewed Person D on the phone. Surveyor asked what reason the provider gave for discharging Resident 2 from the facility. Person D told Surveyor Resident 2 required rehabilitation for weakness. S/he said the MCO would only pay the daily rate for a bed hold until the end of the month when Resident 2 went to the hospital. Person D said Resident 2 did want to return to the facility and was on a wait list to return.

The licensee did not give the Resident 1's legal representative and Resident 2 a 30-day written discharge notice. Resident 1's legal

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N 326	Continued From page 6 representative and Resident 2 were unable to request the Department to review their involuntary discharge.	N 326		
{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 Resident 1 received his/her medications as prescribed by his/her practitioner. Staff did not administer Resident 1's midodrine as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) V2PA11, dated 08/29/2025. Findings include: On 12/04/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 01/27/2025, with multiple diagnoses including Parkinson's disease, hypertension and orthostatic hypotension. Resident 1's individual service plan (ISP), dated 07/20/2025, indicated staff were to administer medications as ordered by the physician.	{N 352}		

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{N 352}	Continued From page 7 Resident 1's October 2025 medication administration record (MAR) indicated an order for midodrine 5 milligrams (mg) tablet with instructions to take by mouth 3 times a day for low blood pressure. "Hold if top (systolic) is greater than 100." The order start date was 01/30/2025. "Midodrine is used to treat low blood pressure (hypotension). It works by stimulating nerve endings in blood vessels, causing the blood vessels to tighten. As a result, blood pressure is increased." (Retrieved from: https://www.mayoclinic.org/drugs-supplements/midodrine-oral-route/description/drg-20064821 on 12/15/2025). On 10/19/2025, morning dose, staff documented Resident 1's blood pressure was 60/48. Staff documentation indicated the midodrine was held. The midodrine should have been administered. On 10/19/2025, noon dose, staff documented Resident 1's blood pressure was 154/85. Staff documentation indicated the midodrine was administered. The midodrine should have been held. On 10/25/2025, evening dose, staff documented Resident 1's blood pressure was 97/71. Staff documentation indicated the midodrine was held. The midodrine should have been administered. Staff documentation indicated Resident 1 was sent to the hospital on 10/30/2025 for episodes of going unresponsive. Resident 1 was admitted to the hospital. On 11/06/2025, Clinical Director (CD) B	{N 352}		

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{N 352}	Continued From page 8 documented: "Resident will no be returning to Mountain Terrace due to needing more medical nursing care with B/P (blood pressure)..." On 12/10/2025 at approximately 9:30 a.m., Surveyor interviewed Administrator A and CD B on the phone. CD B told Surveyor, since the previous survey (SOD V2PA11, dated 08/29/2025), CD B created an audit of all medications with blood pressure parameters and all staff were educated on administering medications with blood pressure parameters. Surveyor explained concerns that Resident 1's midodrine continued to not be administered as prescribed.	{N 352}		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not develop a	N 386		

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comprehensive individual service plan (ISP) for 1 of 4 (Resident 3) residents reviewed.

The provider did not develop an ISP for Resident 3's limited mobility to his/her right hand and arm.

This is a repeat deficiency. See Statement of Deficiency (SOD) IVLX11, dated 07/01/2021.

Findings include:

On 11/24/2025, the Department received a complaint that alleged staff were not providing cares to meet each residents' needs.

On 12/04/2025 at approximately 11:00 a.m., Surveyor interviewed Resident 3. Surveyor observed Resident 3 held his/her right arm at the side and his/her right hand appeared to be contracted. There was a blue splint sitting on a table in the room and exercises were on a paper posted on the wall. Resident 3 told Surveyor his/her right arm and hand was disabled for approximately 6 years. S/he said s/he was right side dominant. Surveyor asked if staff ever put the splint on for him/her. Resident 3 said they put it on once every 2 - 3 weeks. Resident 3 said staff were supposed to put a washcloth in his/her right hand when s/he did not wear the splint, but staff did not do that either. Surveyor asked how often staff helped him/her with exercises and stretching. Resident 3 told Surveyor, "Never."

On 12/04/2025, Surveyor reviewed Resident 3's record.

Resident 3 was admitted to the facility on 02/14/2025. S/he had multiple diagnoses including unspecified injury of right shoulder and upper arm, sequela (long-term effect from past

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N 386	Continued From page 10 injury). Resident 3's ISP, dated 08/15/2025, indicated Resident 3 was oriented to person, place and time. Resident 3 did not have a legal representative. The ISP did not include Resident 3's limited mobility to his/her right arm and hand. On 12/08/2025, Surveyor reviewed orders from a home health agency that was working with Resident 3, which included the following: On 10/27/2025, an occupational therapy (OT) note read, in part: "Please do PROM (passive range of motion) RUE (right upper extremity) & hand don blue splint 2 - 3 (hours) on 3x/day." On 10/30/2025, a physical therapy note read, in part: "Continue with passive range of motion on all plane [sic]." On 11/03/2025, a physical therapy note read, in part: "Recommend to continue with AAROM (active assist range of motion)/PROM." On 11/11/2025, an occupational therapy note read, in part: "remind staff to complete PROM on Pt. (patient) R (right) hand & place wash cloth." On 12/02/2025, an occupational therapy note read, in part: "AROM (active range of motion) LUE (left upper extremity), PROM RUE. Plan d/c (discharge) OT 12/4 & agency 12/5/25 * Please continue range of motion to both arms." On 12/10/2025 at approximately 9:30 a.m., Surveyor interviewed Administrator A and Clinical Director (CD) B. Surveyor explained concerns related to Resident 3 not having a washcloth placed in his/her right hand and his/her	N 386		

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N 386	Continued From page 11 statements of staff not assisting him/her with range of motion. Surveyor was unable to locate Resident 3's limited mobility to his/her right upper extremity in his/her ISP. CD B told Surveyor it was not in Resident 3's ISP. The provider did not develop an ISP for Resident 3's limited mobility to his/her right hand and arm.	N 386		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure staff implemented Resident 3's individual service plan (ISP) as written. Findings include: On 11/24/2025, the Department received a complaint that alleged staff were not providing cares to meet each residents' needs. On 12/04/2025 from approximately 11:00 a.m. to 11:25 a.m., Surveyor interviewed Resident 3 in his/her room. Surveyor observed Resident 3 did not use his/her right arm and his/her right hand appeared to be contracted. Resident 3 told Surveyor his/her right arm and hand have been disabled for approximately 6 years. S/he said it was difficult for him/her as s/he was right side dominant. Surveyor observed a water cup sitting on the table next to Resident 3. Surveyor asked if staff bring him/her water. Resident 3 said s/he had to ask for water. S/he said the water in the	N 388		

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N 388	Continued From page 12 cup was from yesterday. Resident 3 told Surveyor s/he was supposed to have a cup with a handle on it so s/he could pick it up using his/her left hand. Resident 3 said s/he could not pick up the water cup with his/her left hand without a handle. On 12/04/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 02/14/2025. S/he had multiple diagnoses including unspecified injury of right shoulder and upper arm, sequela (long-term effect from past injury). Resident 3's ISP, dated 08/15/2025, indicated Resident 3 was oriented to person, place and time. Resident 3 did not have a legal representative. The ISP read, in part: "Requires special eating utensils such as foam/padded utensils, rimmed plate, and cup with handles on sides." On 11/13/2025, home health agency documented, in part: "pt (patient) unable to pick water up ind. (independently) please offer water ... reports not having water since yest. (yesterday) time now 1014 (10:14 a.m.)." On 11/30/2025, Clinical Director B documented, in part: "Offer fluids as much as possible as resident struggle [sic] to reach cup." The provider did not ensure Resident 3 was provided water in a cup with handles per his/her written ISP.	N 388		
N 489	83.44(2)(a) Rooms clean and free from odors.	N 489		

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 _____	R-C 12/10/2025

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 489	Continued From page 13	N 489		

The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure all rooms were kept clean and free from odor.

Findings include:

On 10/02/2025, the Department received a complaint alleging resident rooms were not kept clean from dirty laundry and bed linens were soiled.

On 12/04/2025 at approximately 10:30 a.m., Surveyor interviewed Resident 4 in his/her room. Surveyor asked if Resident 4 had any concerns. Resident 4 told Surveyor staff did not put her things away. Surveyor observed a laundry basket with clothes folded in it, there was a pile of dirty laundry sitting on the floor next to the closet. Surveyor asked if staff placed the dirty laundry on the floor. Resident 4 said they did.

On 12/04/2025 at approximately 12:00 p.m., Surveyor observed Resident 5's room. Resident 5's bed was not made, and his/her sheets were visible from his/her doorway. The sheets on the bed and along with the incontinent pad on the bed were visibly soiled and there was an odor coming from the room.

On 12/04/2025 at approximately 1:55 p.m., Surveyor interviewed Resident 5 in his/her room. Resident 5's bed remained unmade with soiled bed linens. Surveyor asked Resident 5 if staff made his/her bed for him/her. Resident 5 replied, "Sometimes." Surveyor asked Resident 5 if staff

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N 489	Continued From page 14 did his/her laundry. Resident 5 replied, "Sometimes." On 12/04/2025 at approximately 2:00 p.m., Surveyor observed Resident 4's room. Resident 4's dirty laundry remained on the floor and his/her clean laundry was still folded in the basket. On 12/10/2025 at approximately 9:30 a.m., Surveyor interviewed Administrator A and Clinical Director (CD) B. Surveyor explained concerns related to the resident rooms. CD B told Surveyor, Resident 5's room was going to be put on daily checks for bed linens. CD B said the overnight staff do a lot of the laundry and place the baskets in the residents' rooms, then staff during the day should be putting the laundry away. The provider did not ensure all rooms were kept clean and free from odor.	N 489		