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 _____	C 03/03/2026

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 03/03/2026, Surveyor conducted a complaint investigation at Country Terrace Black River Falls II. The complaint was substantiated. One deficiency was identified. Census: 18	N 000		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received adequate medication administration services to meet his/her needs. Staff did not follow Resident 1's physician's order to hold Eliquis (anti-coagulant medication) prior to Resident 1's scheduled lumpectomy for breast cancer. Resident 1 had to reschedule the lumpectomy. Findings include:	N 432		

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

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N 432	Continued From page 1 On 10/24/2025, the Department received a complaint that alleged the provider did not follow medication orders. On 03/03/2026, Surveyor reviewed Resident 1's record. A fax, dated 10/17/2025, from Resident 1's health care provider indicated Resident 1 was scheduled for a right breast lumpectomy on 10/24/2025. The "Pre-Procedure Medication Instructions" included the following order: Eliquis 2.5 mg (milligrams) - "Medications Adjustments for Procedure: Take last dose on 10/20. Do NOT take this again before procedure." On 10/21/2025, Resident 1's home health nurse documented, in part: " ... Pt (patient) reports feeling anxious for upcoming procedure ..." Resident 1's medication administration record (MAR) for October 2025 indicated Resident 1 received Eliquis 2.5 mg at 8:00 a.m. and at 5:00 p.m. The MAR indicated the following: 10/21/25 at 8:00 a.m. - staff initialed and circled their initials. The back of the MAR read, "Eliquis held pre-procedure instructions." 10/21/2025 at 5:00 p.m. - staff initialed the medication was administered. 10/22/2025 at 8:00 a.m. - staff initialed and circled their initials. There was no documentation on the back of the MAR. 10/22/2025 at 5:00 p.m. - staff initialed the medication was administered. 10/23/2025 at 8:00 a.m. - Staff documented "hold". The back of the MAR read, "Eliquis held pre-procedure instructions." 10/23/2025 at 5:00 p.m. - staff initialed the	N 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 432	Continued From page 2	N 432		

medication was administered.
10/24/2025 at 8:00 a.m. - Staff documented "hold".

A fax, dated 10/24/2025, indicated Resident 1's right breast lumpectomy was scheduled for 10/31/2025. The fax included the same "Pre-Procedure Medication Instructions" that were previously ordered.

On 03/03/2026 at approximately 12:00 p.m., Surveyor interviewed Director A, Assistant Director (AD) B, and Administrator D. Surveyor asked why Resident 1's lumpectomy was rescheduled. AD B told Surveyor Former Director (FD) C put the pre-procedure medication instruction packet in the MAR but did not make changes to the actual MAR. AD B told Surveyor staff noticed Resident 1 received his/her Eliquis that was supposed to be held. Staff called AD B to inform him/her that Resident 1 received the Eliquis. AD B said s/he told staff to call the hospital and inform them and also to call Resident 1's family. AD B said FD C should have informed all employees of the new orders and should have put X's on the MAR when Resident 1 was to hold his/her medication. Administrator D told Surveyor FD C and employees that administered the Eliquis received corrective action and additional training.

Resident 1 did not receive adequate medication administration services to meet his/her needs resulting in having to reschedule Resident 1's lumpectomy for breast cancer.