

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0015263	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/31/2026
NAME OF PROVIDER OR SUPPLIER COUNTRY TERRACE TOMAHAWK		STREET ADDRESS, CITY, STATE, ZIP CODE 300 THEILER TOMAHAWK, WI 54487		
(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 08/26/2026, Surveyor conducted a complaint (x4) investigation at Country Terrace Tomahawk. Data collection continued through 08/31/2026. Two of 4 complaints were substantiated. One deficiency was identified. The deficiency was a repeat deficiency. See Statement of Deficiency (SOD) PT3612, dated 01/09/2025. Census: 27	N 000		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision 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 services adequate to meet the needs of Resident 1 in the following area: Supervision. This is a repeat deficiency, cited for the 2nd time. See Statement of Deficiency (SOD), SOD PT3612, dated 01/09/2025.	N 426		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 426	Continued From page 1 Findings include: The facility is licensed to care for 33 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, and terminally ill. Between 07/15/2026 and 07/21/2026, the Department received two complaints alleging supervision concerns with Resident 1. The complaints indicated Resident 1 eloped 5 times between May 2026 and July 2026. On 08/26/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 07/07/2025. Resident 1 discharged on 07/20/2026. A discharge note indicated that Resident 1 was discharged to a secure setting due to frequent elopements. Resident 1 had the following diagnoses: congestive heart failure, dementia (mild), hypothyroidism, anxiety/depression, down syndrome. Records indicated Resident 1 was placed on 15-minute checks on 07/12/2026 and Resident 1 wore a Wanderguard. Surveyor reviewed nurse's notes. Nurse's notes, read in part: 05/05/2026 8:00 PM: "Resident wandered the facility and went out on the back patio off and on." 05/10/2026 1:00 PM: "Resident had both meals, was in and out (,) staying on facility property, and wondered the halls." 05/15/2026 9:00 PM: "Resident walked down driveway and left down the road. Staff had to bring [him/her] back..."	N 426		

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N 426	Continued From page 2 05/20/2026 (1:00 PM): "Resident went outside 10 times during shift." 05/20/2026 (9:00 PM): "Resident went outside about 6 x [sic] today." 05/21/2026 (1:00 PM): "Resident went outside 20 times during shift." 05/24/2026 (2:00 PM): Late Entry. Resident wandered out A hall door down into the field and started walking west on Theiler Drive, staff attempted multiple times to get resident to stop and turn around [sic] resident became aggressive and stated [s/he] was going (to) throw writer to the ground [sic] resident kept walking and took a right handed turn and headed north towards Amelse Storage Units. Resident then ran into County Hwy S where staff had to intervene [sic] as cars were not stopping [sic] (and doing) speeds of 45 mph. Resident began slapping, punching, kicking at staff when staff tried to get [him/her] out of the hwy (highway)..." 05/26/2026 (9:00 PM): "Resident elopeing [sic] multiple times during shift." 05/27/2026 (9:00 PM): "Resident went outside, walking to the road, walking half way down the road to S (Hwy S), then going up random driveway, assistant director came with a car to get resident back to facility..." 05/29/2026 (9:00 PM): "Resident wandered outside most of shift..." 06/10/2026 (1:00 PM): "Resident walked around outside and stayed on property." 06/12/2026 (1:00 PM): "Resident walked around	N 426		

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N 426	Continued From page 3 outside most of shift." 06/20/2026 (1:00 PM): "Added Note: Resident walked out the front door and straight down the road to highway S. Staff was following behind but resident got to a group of people that called the facility to let us know but we were already following behind. Director notified. Resident was redirected to facility." 06/25/2026 (10:00 PM): "Resident eloped this shift. Please see incident report." 06/29/2026 (9:00 PM): "Resident walked the halls an [sic] went outside [sic] no elopement attempts..." 07/10/2026 (9:00 PM): "Resident walked around the halls and the parking lot..." 07/11/2026 (9:00 PM): "Resident was found in a staff member's car, when staff asked [him/her] to get out [sic] resident started to get aggressive [sic] trying to hit and kick staff and the car. Resident got out after 10 minutes and calmed down." 07/12/2026 (9:00 PM): "Writer saw resident walking down A-hall around 3:30 PM during 4 PM med pass, once writer was done, writer was bringing other residents for supper around 4:15 PM. Writer was notified from another staff member (that) resident was with the police down the road. Writer was then notified resident was getting transported to the emergency room. Resident returned to the facility around 6:40 PM with [his/her] family member and director..." 07/15/2026 (1:00 PM): "Resident spent most of shift on couch in lobby. Got up around 10 AM and	N 426		

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N 426	Continued From page 4 started wandering halls (and) seeking exits. Got outside via A-hall door, but was redirected back inside.." 07/15/2026 (9:00 PM): "After 15 min check, Resident [sic] walked out side [sic] and was found walking down the road in front of building. Was redirected back in to [sic] the building. Resident then walk [sic] the halls of building..." 07/19/2026 (9:00 PM): "Resident walked the halls & outside..." 07/20/2026 (1:00 PM): "Resident left with [sister/brother] around 9:30 AM to move to another facility." According to Resident 1's individual service plan (ISP), dated 06/11/2026, "[Resident 1] will wander outside of the facility. [Resident 1] has not left the facility, but if this would happen, [his/her] Guardian has placed Apple Air Tags in [his/her] shoes for safety." According to Resident 1's ISP, the annual evaluation noted, "[Resident 1] has eloped from the facility. [Resident 1] is on 15 min check. Staff provide activities and redirect as needed to the facility. Guardian and MCO (managed care organization) are working together to find secure placement." According to facility self reports, Resident 1 eloped on the following dates and times: - 05/18/2026 at 11:40 AM: Resident 1 "eloped of the property." The police were contacted. - 05/19/2026 at 1:26 PM: "Resident left parking lot running after a white car down the road toward Hwy S. Resident was a minimum (of) 50 yards away from driveway before stopping for staff.	N 426		

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N 426	Continued From page 5 Called 911 for assistance." - 06/20/2026 at 1:18 PM: "Resident walked out the front door and straight down the road to highway S. Staff was following behind but resident got to a group of people that called the facility to let us know but we were already following behind..." - 06/25/2026 at 4:00 PM: "Staff noticed they hadn't see [sic] the resident for about 20 mins [sic] so they informed other staff and they all started looking for the resident inside and outside the facility and notified the director and [s/he] assisted looking for the resident [sic] when we were unable to find [him/her](,) the director called 911." - 07/12/2026 at 4:10 PM: "Staff reported that [Resident 1] was walking the halls at our facility around 3:30/3:45 PM and that they received a call from local law enforcement (at) 4:10 PM with the question if we 'were missing a resident' -describing [Resident 1] to the program assistant." - 07/15/2026 at 4:15 PM: "Staff member watched [Resident 1] depart the parking lot onto the road at 4:15 (PM) after making several attempts to get [him/her] inside. Once on the road [sic] the Program Asst. told [Resident 1] that it was dinner time and [Resident 1] complied and came back onto the property..." The provider gave Resident 1 a 30-day notice on 06/29/2026. The 30-day notice, read in part, "Per state code 83.31(4)(b)5, there is an imminent risk of serious harm to the health or safety of the residents. Due to [Resident 1] being an exit seeker and elopement risk we can no longer care	N 426		

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N 426	Continued From page 6 for [him/her] safely." On 08/26/2026 at approximately 9:40 AM, Surveyor interviewed Caregiver B. Surveyor asked about the supervision of Resident 1. Caregiver B reported that Resident 1 "had special needs and eloped a lot." Caregiver B commented, "We did the best we could with [him/her]." Caregiver B stated, "[Resident 1] would have benefited from one-on-one supervision." On 08/26/2026 at approximately 11:00 AM, Surveyor interviewed Assistant Director (AD) C. Surveyor asked about the supervision of Resident 1. AD C reported that staff would try to redirect Resident 1 with snacks, but "towards the end, it was impossible to keep [him/her] from eloping; [s/he] was always trying to get out of here." AD C commented, "[Resident 1] would have benefited from one-on-one supervision all day." On 08/26/2026 at approximately 12:24 PM, Surveyor interviewed Caregiver D. Surveyor asked about the supervision of Resident 1. Caregiver D stated that Resident 1 "kept getting outside and [s/he] could become combative (towards staff)." Caregiver D reported, "We were stretched pretty thin (3 staff on the floor) when [Resident 1] was getting away; [s/he] eloped a lot." On 08/26/2026 at approximately 3:15 PM, Surveyor interviewed Caregiver E. Surveyor asked about the supervision of Resident 1. Caregiver E stated, "We would keep tabs on [Resident 1] the best we could. [S/He] would always go towards the doors. [S/He] liked to exit around dinner time. We did everything we could."	N 426		

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N 426	Continued From page 7 On 08/26/2026 at approximately 3:35 PM, Surveyor interviewed Caregiver F. Surveyor asked about the supervision of Resident 1. Caregiver F reported that Resident 1 had a Wanderguard on and was on 15-minute checks prior to his/her discharge. Caregiver F stated, "I think we did everything we could to prevent [him/her] from eloping. We could have kept a closer eye on [Resident 1] if we had additional staff." On 08/26/2026 at approximately 4:10 PM, Surveyor interviewed Director A. Surveyor asked about the supervision of Resident 1. Director A reported, "We kept eyes on [Resident 1]; [s/he] was busy. Surveyor asked Director A if additional staff would have made a difference in preventing Resident 1's elopements. Director A responded, "I don't think so." On 08/27/2026 at approximately 9:21 AM, Surveyor interviewed Guardian G via telephone. Surveyor asked about the supervision of Resident 1. Guardian G commented, "It's a horrible place. [Resident 1] was neglected." Guardian G stated that the facility "was not equipped to care for [him/her]; they never had an extra caregiver to provide one-on-one supervision." On 08/28/2026 at approximately 9:40 AM, Surveyor interviewed Resident 1's case management team via telephone. Surveyor asked about Resident 1's supervision. Caseworker H stated that additional staff would have helped Resident 1. Caseworker H indicated that Inclusa's case management team spoke to Director A on 05/26/2026 and on 06/11/2026 about one-on-one supervision for Resident 1. According to Caseworker H, Inclusa was willing to request and provide additional money for one-on-one	N 426		

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N 426	Continued From page 8 supervision. Caseworker H reported that one-on-one supervision during day light hours would have benefited Resident 1 and Director A "told us they could not staff one-on-one." Caseworker H reported that Includa gave the provider a 30-day notice on 06/26/2026 and the provider sent Includa a 30-day notice for Resident 1 on 06/29/2026. On 08/31/2026 at approximately 10:18 AM, Surveyor interviewed Director A via telephone. Surveyor asked about the oversight and supervision of Resident 1. Director A stated, "It was challenging to keep track of [him/her]. [S/He] needed more oversight and supervision - we tried." Director A reported that the provider gave Resident 1 a 30-day notice on 06/29/2026." Director A commented that Resident 1 would have benefitted from one-on-one supervision. The provider did not ensure adequate supervision for Resident 1.	N 426		