STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014050	A. BUILDING: _____ B. WING _____	C 09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE OF WI INC 26	533 E TIMBER RHINELANDER, WI 54501

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N 000	Initial Comments On 09/17/2024 and 09/18/2024, Surveyor conducted a complaint (x7) investigation at Country Terrace of WI Inc. 26. Data collection continued through 09/23/2024. Five of 7 complaints were substantiated. Five deficiencies were identified. Census: 10	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure residents were free from mistreatment (verbal and mental abuse). Findings include: On 07/10/2024, the Department received complaints alleging residents were being verbally and mentally abused by caregivers. The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease,	N 348		

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

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N 348	Continued From page 1 advanced aged, and terminally ill. On 09/17/2024 at approximately 12:05 PM, Surveyor interviewed Caregiver F. Caregiver F reported that s/he started working at the facility on 07/01/2024. Caregiver F stated, "It was a [expletive] when Former Director (FD) C worked here." Caregiver F reported, "[Caregiver I] raises [his/her] voice and swears at the residents." Caregiver F indicated that s/he brought these concerns to Former Director (FD) C in July 2024. Caregiver F stated, "[FD C] did not do anything about it." Caregiver F reported that families have complained about Caregiver I. On 09/17/2024 at approximately 2:00 PM, Surveyor interviewed Person J. Person J reported, "There is a staff member that does not talk warm and fuzzy towards residents." Person J stated that Caregiver I raises his/her voice sometimes when talking to residents and "I heard [him/her] talk rudely towards others." Person J commented that Caregiver I "does [his/her] job well" and things have gotten better around the facility. On 09/18/2024 at approximately 12:51 PM, Surveyor interviewed Person G via telephone. Person G reported that hospice staff have witnessed "unprofessional interactions" over the past few months between Caregiver I and residents. Person G indicated that the "unprofessional interactions" included Caregiver I raising his/her voice and making rude comments towards residents. On 9/18/2024 at approximately 2:30 PM, Surveyor interviewed Director A. Director A reported that Director A was hired in August 2024 and FD C was terminated a few weeks prior to	N 348		

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N 348	Continued From page 2 Director A starting. Director A stated that Director A had been "addressing staff interactions with residents." Director A indicated that Director A was unable to locate prior investigations involving Caregiver I. Director A reported that Director A prepared an "Employee Warning Notice" and plans to review it with Caregiver I this week. Director A indicated that Director A planned to meet with Caregiver I and give Caregiver I a final warning for his/her conduct (being disrespectful towards residents). On 09/18/2024 at approximately 2:47 PM, Surveyor interviewed Person H. Person H reported that [Managed Care Organization] started getting complaints about staff interactions with residents and resident care concerns in July 2024. On 09/19/2024 at approximately 1:55 PM, Surveyor interviewed Caregiver I. Caregiver I reported that s/he started working on April 2024. Caregiver I reported that s/he worked 3:00 PM to 11:00 PM and mostly worked alone. Surveyor asked Caregiver I if s/he had any concerns with staff interactions with residents. Caregiver I responded, "I am aware of false accusations being made about myself and I would never treat my residents that way." Caregiver I denied mistreating residents in any way. On 09/19/2024 at approximately 2:47 PM, Surveyor interviewed Director A via telephone. Director A reported that Caregiver I would be receiving his/her final warning for treating residents with disrespect. On 09/19/2024, Surveyor reviewed Caregiver I's record. Caregiver I was hired on 04/26/2024. According to April through August 2024	N 348		

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N 348	Continued From page 3 schedules, Caregiver I worked multiple AM and PM shifts. Caregiver I's record did not contain any disciplinary actions. On 09/23/2024 at approximately 9:15 AM, Surveyor interviewed Director A via telephone. Surveyor asked for staff investigations. Director A reported that Director A was unable to locate prior staff investigations. Director A reported that Director A would be faxing additional information to Surveyor regarding "substantiated abuse" involving Caregiver I. On 09/23/2024 at approximately 9:43 AM, Surveyor received an e-mail from Director A. Director A e-mailed an "Employee Warning Notice" for Caregiver I. The Employee Warning Notice, noted that Caregiver I received a warning for "verbal misconduct" on the following dates: 09/09/2024 (2 x), 09/10/2024 and 09/11/2024. On 09/23/2024 at approximately 4:45 PM, Surveyor interviewed Director A via telephone. Director A confirmed Caregiver I was given a final warning on today's date (09/23/2024) for verbal misconduct and being disrespectful towards residents. The provider did not ensure all residents were free from verbal and mental mistreatment.	N 348		
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	N 352		

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N 352	Continued From page 4 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 all prescribed medications in the dosage and at intervals prescribed by a practitioner. Findings include: On 07/10/2024, the Department received a complaint alleging that medication errors were occurring at the facility. The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged and terminally ill. On 09/18/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 06/29/2022. According to Resident 1's medication administration record (MAR), Resident 1 was prescribed Amlodipine Besylate 5 MG on 07/11/2022. According to a "Physician's Fax" sheet to Resident 1's physician, dated 07/26/2024, Former Director (FD) C, noted in part, "Resident had an order for Amlodipine that was [D/C'd] (discharged) 4/2/24 - order was not noticed. Resident was receiving this [med] up until 7/19 (2024) - no ill effects, no falls, no issues. [POA] (power of attorney) aware, Resident aware, [med] discontinued." Resident 1's record contained an August 2024 MAR for Amlodipine Besylate 5 MG and the MAR noted Resident 1 was given Amlodipine Besylate 5 MG at 8:00 AM daily in the month of August 2024. On 09/23/2024 at approximately 3:23 PM,	N 352		

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N 352	Continued From page 5 Surveyor interviewed Director A via telephone. Director A verified that Resident 1's July 2024 MAR included Amlodipine Besylate 5 MG. Director A commented that the MAR "should have been pulled." Director A verified that staff signed off on Resident 1's August 2024 MAR as administering Amlodipine Besylate 5 MG each day during the month of August 2024.	N 352		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a temporary service plan to meet the immediate needs of Resident 3. Findings include: The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged and terminally ill. On 09/23/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted on 07/08/2024. Resident 3 died on 07/21/2024. Resident 3's record did not contain a temporary service plan or individual service plan (ISP). On 09/23/2024 at approximately 11:15 AM, Surveyor interviewed Assistant Director (AD) E.	N 385		

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N 385	Continued From page 6 AD E confirmed Resident 3 was admitted on 07/08/2024 and died on 07/21/2024. AD E reported that AD E could not locate a temporary service plan, care plan or comprehensive ISP for Resident 3.	N 385		
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 record review and interview, the provider did not develop a comprehensive individual service plan (ISP) for Resident 2 within 30 days after admission and based on the assessment under sub. (1). Findings include: The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged and terminally ill.	N 386		

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N 386	Continued From page 7 On 09/23/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/30/2023. Resident 2 died on 07/15/2024. Resident 2's record did not contain a comprehensive ISP. On 09/23/2024 at approximately 11:15 AM, Surveyor interviewed Assistant Director (AD) E via telephone. AD E confirmed Resident 2 was admitted on 10/30/2024 and died on 07/15/2024. AD E confirmed that Resident 2's ISP was "blank." Surveyor asked AD E if there were any additional ISPs or care plans for Resident 2. AD E reported that there were no additional ISPs or care plans available for Resident 2.	N 386		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty	N 397		

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N 397	Continued From page 8	N 397		

and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at least one qualified resident care staff was present in the community based residential facility (CBRF), when one or more residents were present in the CBRF.

Findings include:

Wisconsin Administrative Code defines a "qualified resident care staff" as an employee who has successfully completed all of the applicable training and orientation under subch. IV.

On 07/10/2024, the Department received a complaint alleging a caregiver who worked the overnight (NOC) shift was not medication trained and the facility was not meeting resident needs.

The facility is licensed to serve up to 15 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged and terminally ill.

On 09/18/2024, Surveyor reviewed the July 2024 schedule. Caregiver D worked multiple NOC shifts alone in July 2024.

On 09/18/2024, Surveyor reviewed Caregiver D's record. Caregiver D was hired on 09/09/2023. Caregiver D completed medication administration training on 09/06/2024.

On 09/18/2024 at approximately 2:30 PM, Surveyor interviewed Director A and Director B. Director A and Director B confirmed Caregiver D

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N 397	Continued From page 9 worked multiple NOC shifts in July 2024 without being trained to pass medications. Director B reported that Caregiver D completed medication training on 09/06/2024. Director A provided surveyor with a copy of The Wisconsin Community-Based Care and Treatment Training Registry print out verifying Caregiver D completed medication training on 09/06/2024. On 09/18/2024 at approximately 3:30 PM, Surveyor interviewed Caregiver D via telephone. Caregiver D reported that his/her hire date was 09/09/2023. Caregiver D stated that s/he worked several NOC shifts alone in July 2024 and was not medication trained until 09/06/2024. Caregiver D reported that Caregiver D did not pass medications when s/he worked alone. Caregiver D reported that Caregiver D started working NOC shifts at the beginning of April 2024 and routinely worked alone. The provider did not ensure a qualified staff was present when residents were present during several NOC shifts in July 2024.	N 397		