STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015263	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY TERRACE TOMAHAWK	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 03/19/2024, Surveyor conducted a complaint investigation investigation at Country Terrace Tomahawk. One deficiency was identified. The complaint was substantiated. Census: 23	N 000		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that an adequate number of staff were working on each shift to care for the needs of each resident. Findings include: On 2/20/2024, the department received a complaint alleging that a resident was not receiving the care s/he required for personal hygiene. On 03/19/2024 at 9:07 AM, the staffing consisted of Director in Training (DIT) A, Personal Assistant (PA) B (who indicated s/he was passing medications, doing caregiving tasks, acting as a cook, and cleaning), PA D (who was doing caregiver tasks), and Activity Assistant (AA) C (who was conducting activities and was helping on the floor).	N 396		

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

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N 396	Continued From page 1	N 396		

There were 23 residents in the client groups of physically disabled, terminally ill, irreversible dementia/Alzheimer's, and advanced aged.

The activity calendar on the bulletin board stated 9:30 AM balloon toss, 10:30 AM Bingo, and 1:00 PM Crafting. The balloon toss did not take place but Bingo did. The crafting activity did not take place.

On 03/19/2024 at 9:24 AM, Surveyor went down the hall toward Resident 1's room. There was a very strong urine smell detected 3 rooms before Resident 1's room. The odor increased at the open doorway of Resident 1's room. Resident 1 was in bed partially covered with a throw blanket. The room was dark and Resident 1's wheelchair was approximately 4 feet from the foot of the bed. Surveyor noted the carpeting in the room had numerous stains. At 9:48 AM, Surveyor observed Resident 1 sitting at the edge of the bed in a soiled t-shirt and pajama pants. Resident 1's pants appeared wet from just under the waist band to the knees. Surveyor observed Resident 1's doorway and no staff approached the room to offer any assistance or perform cares, from 9:48 AM to 10:54 AM.

At 10:53 AM, Surveyor observed Social Worker (SW) E greet Resident 1 and turn on the light in the room.
At 10:54 AM, Surveyor observed Resident 1 in the same clothing and slowly propelling himself down the hall to the common areas. PA B saw Resident 1 in the hallway and greeted Resident 1 with, "How ya doing?" Surveyor observed that the mattress on Resident 1's bed had a 12-inch round indentation and an oval shaped large dark brown stain on the fitted sheet. The stain covered approximately three quarters of the bed. The

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N 396	Continued From page 2	N 396		

sheet appeared wet, and the urine odor was very intense. At 10:59 AM Resident 1 seated himself at a table. Resident 1 had a strong odor of urine, feces, and sweat. Resident 1's glasses were covered in a thick brown substance. At 11:02, PA B asked the resident 3 times, "Can we go to your room to change your clothes?" Resident 1 said no each time and added that s/he wanted food. At 11:07 AM, PA B asked Resident 1 if s/he could wait as PA B needed to help another resident. At 11:43, Surveyor overheard a staff member announce that the food was not ready yet. Meal service began at 11:56 AM. At 12:18 PM, Surveyor observed Resident 1's room after meal service and it was in the same condition as before.

On 03/19/2024 at 10:53 AM, Surveyor interviewed SW E. SW E stated Resident 1's needs were not being met and the managed care organization was attempting to find placement to a skilled nursing facility but had not been successful. SW E stated the staff were not assisting Resident 1 with personal cares or cleaning Resident 1's room. SW E stated a plan was put in place in June to have staff clean Resident 1's room when s/he was out at meals but over the last 2 months, hospice staff have noted increased incontinence and increased concerns about the cleanliness of Resident 1 and his/her room.

On 03/19/2024 at 2:27 PM, Surveyor interviewed AA C about staffing levels. AA C stated the staff are overworked with long shifts. AA C stated s/he had been working the floor for the last month and today was the first time an activity was held in the last month, when s/he was able to set up a Bingo game. AA C stated s/he worked Monday through Friday, 6:30 AM to 2:30 PM. AA C stated that

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N 396	Continued From page 3	N 396		

when there are only 2 staff scheduled for the day and evening shifts, staff are not able to follow toileting schedules and clean the residents' rooms. AA C stated there was no cook for several months. AA C stated that approximately 2 weeks prior, s/he and PA B had gone to DIT A about needing help and there had been no change. AA C stated there had been no menu since the cook left and, "We kinda wing it." In addition, AA C stated s/he felt sorry for the other residents in the dining room that had to see and smell Resident 1. AA C stated staff changed Resident 1's bedding last week. AA C stated that staff try to change out Resident 1's bedding while s/he is in the dining room but that does not happen if staff are busy serving the meals.

At 2:47 PM, Surveyor interviewed PA B. PA B stated the usual staffing was one personal care worker and one person to pass medications on all 3 shifts. PA B stated the care staff was also responsible to cook and serve the meals. PA B stated s/he had come in at 2:00 AM today and made the tuna fish casserole. PA B stated that a lot of the meals were egg bakes and casseroles as these were made by the night shift. PA B stated the current staffing pattern of only 2 persons per shift means the residents' rooms do not get cleaned, and showers are not done. PA B stated Resident 1 frequently refuses cares, is incontinent, and will go in his/her pants rather than use the toilet. PA B stated that in the past there were more staff on each shift and staff were able to clean Resident 1's room when s/he was at lunch. PA B stated it did not happen as there were 2 staff on the floor to cook, serve, and clean up the meal and AA C was already helping on the floor and serving food.

At 3:14 PM, Surveyor interviewed PA D. PA D

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N 396	Continued From page 4	N 396		

stated there was usually 2 staff per shift and AA C had been helping. PA D stated there was no cook or housekeeper. PA D stated the rooms were not cleaned. PA D stated there was a list of rooms to be cleaned and nobody did the cleaning. PA D stated each resident's room was to be cleaned on their shower day but that was not happening. PA D stated there were no cleaning rags, no sanitizers, and no toilet bowl cleaners even if they had the time. PA D stated Resident 1 would become violent and every day s/he was soaked in urine from his/her knees to his/her groin. PA D stated Resident 1's room was not cleaned while s/he was at lunch because there was not enough staff. PA D stated that if there were 3 on the floor, it could get done.

On 03/19/2024, at 3:30 PM, Surveyor observed that DIT A had changed into scrubs to work as a caregiver. Surveyor interviewed DIT A. DIT A stated there were many shifts in which there were only 2 staff members for each shift. DIT A stated that if there was no one else to work, the shifts fall on him/her. DIT A stated s/he worked a 20-hour shift last month. DIT A stated the best staffing they can do is 2 on each shift. DIT A stated there were 2 staff members on medical leave and 4 staff put in their 2-week notice a week ago because of the long shifts. DIT A stated 2 staff was not enough to get things done and it had been like that for the last 3 weeks. DIT A stated s/he had gone to his/her superiors for assistance and had gotten little to no support. DIT A was advised to call other corporate run homes in the area, only to find out no one wanted to take a shift. DIT A stated there had been no activities in the last 3 weeks as AA C had been helping with the caregiving. DIT A stated that recently there had been 2 hires that never showed up for work. DIT A stated there was not enough time to

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N 396	Continued From page 5 reapproach Resident 1 about his/her room and his/her personal hygiene. DIT A stated that one of Resident 1's reclining chairs was cleaned and airing out in the garage, but that fix would only last a couple of days. On 03/19/2024 at approximately 12:15 PM, Surveyor reviewed the staff schedule for January, February, and March. The schedule corroborates the staffs' comment that there were only 2 people on each shift over the last month. Over the course of the last 3 months, the total number of staff had gone down from 18 people to 12 people. In January, on the majority of days, the provider had 3 on per shift and that continued through mid-February. Staff were regularly scheduled for 12-hour and 16-hour shifts. In the month of March, PA B was usually scheduled for 12-hour shifts from 2:00 AM to 2:00 PM. DIT A had picked up numerous shifts as a caregiver. In February, DIT A worked 17 days in a row, and in March, worked 14 days in a row.	N 396		