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 _____	R-C 06/10/2024

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 06/06/2024, Surveyor conducted a complaint investigation and verification visit at Country Terrace Tomahawk for Statement of Deficiency (SOD) ERU212 and SOD 5HN211. Data was collected through 06/10/2024. The complaint was substantiated. Two deficiencies were identified. One of the 2 deficiencies was a repeat deficiency. See SOD ERU212, dated 02/08/2024. Census: 19 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
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 each resident received all medications as prescribed. Resident 2 did not receive his/her scheduled lidocaine patches as ordered by his/her hospice provider. Resident 3 did not receive his/her scheduled	N 352		

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

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N 352	Continued From page 1 aspirin and vitamin D as ordered. This is a repeat deficiency. See Statement of deficiency ERU212, dated 02/08/2024. Findings include: RESIDENT 2 On 06/06/2024, Surveyor reviewed Resident 2's record. Resident 2 had multiple diagnoses, including mild cognitive impairment, anxiety, depression, osteoarthritis, and bursitis. S/he was on hospice. The medication administration record (MAR) indicated Resident 2 had an order for a lidocaine 4% patch to be applied once daily to his/her lower back and removed after 12 hours. The May and June 2024 MAR indicated Resident 2 did not receive his/her lidocaine patch from 05/19/2024 to 06/06/2024. On 06/06/2024 at approximately 2:15 p.m., Surveyor interviewed Director A and Caregiver C. Director A was new to his/her position and just started on 05/15/2024. Caregiver C was the previous assistant director but was recently off on leave. Surveyor asked why Resident 2 was not receiving his/her lidocaine patch. Caregiver C told Surveyor that hospice provided the lidocaine patches. Surveyor asked if there was any documentation of communication to hospice about Resident 2 needing a refill of the lidocaine patches. Caregiver C said s/he believed hospice was contacted. Director A said s/he would review documentation. On 06/10/2024 at approximately 10:30 a.m., Surveyor interviewed Hospice Director (HD) D on	N 352		

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N 352	Continued From page 2	N 352		

the phone. Surveyor asked if the provider had contacted hospice regarding Resident 2 needing refills of his/her lidocaine patch. HD D reviewed Resident 2's notes. HD D told Surveyor they received a call today (06/10/2024) for Resident 2's lidocaine patches. HD D told Surveyor this was the only documentation s/he found stating Resident 2 was out of his/her lidocaine patches.

RESIDENT 3

On 06/06/2024, Surveyor reviewed Resident 3's record. Resident 3 had multiple diagnoses, including: organic brain syndrome, multiple sclerosis, spastic syndrome, diabetes, and hypertension.

Resident 3's MAR indicated s/he had orders to receive aspirin 81 milligrams once daily and vitamin D3, 50 micrograms once daily. Both orders indicated the VA (Veterans Affairs) supplied them. Resident 3's May and June 2024 MARS indicated Resident 3 did not receive his/her prescribed aspirin from 05/01/2024 to 06/03/2024. Resident 3 did not receive his/her prescribed vitamin D3 from 05/01/2024 to 06/06/2024.

On 06/06/2024 at approximately 2:15 p.m., Surveyor interviewed Director A and Caregiver C and requested any documentation indicating the provider attempted to refill Resident 3's aspirin and vitamin D3. Director A said s/he would look for faxes.

On 06/10/2024, Director A emailed Surveyor, stating, in part: "I am still trying to find documentation on the refill request. I know I did talk to [name] Pharmacy as well as hospice this morning for refills on [Resident 2's] patch. I also

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N 352	Continued From page 3 this morning called in the refills for [Resident 3's] medications as well as speaking with [his/her] Nurse [sic] at the VA to make sure that we have all the medications that are needed." On 06/10/2024 at approximately 2:00 p.m., Surveyor interviewed Director A on the phone. Director A told Surveyor that s/he would be auditing the medication cart weekly to ensure medications are being refilled timely.	N 352		
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 record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was implemented as written. Staff pushed Resident 1 while Resident 1 was seated on his/her wheeled walker. Resident 1 fell backwards and struck his/her head on the ground. Findings include: On 03/28/2024, the Department received a complaint with allegations a staff member used a resident's wheeled walker inappropriately, which caused the resident to fall. On 06/06/2024, Surveyor reviewed Resident 1's record. Resident 1 no longer resided at this facility. Resident 1 was admitted to the facility on 08/15/2022. His/her ISP, dated 09/01/2022, last signed on 04/04/2023, indicated Resident 1 used	N 388		

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a 4-wheeled walker for assistance with walking. The ISP indicated Resident 1 ambulated independently with his/her wheeled walker.

An incident report, dated 03/25/2024, read: "Resident en route to transport vehicle c (with) staff assist; Resident seated on adaptive walker while staff assisted; Resident put feet down while staff still pushing; Resident fell backward and hit head on sidewalk." The report indicated Resident 1 went to the emergency room (ER).

A staff note, dated 03/25/2024, read: "Resident was leaving a [sic] facility for an appointment transporting via transport service. Staff was assisting [him/her] using adaptive walker. Resident put feet down, knocking walker back and resident hit [his/her] head. EMS (emergency medical services) and POA (power of attorney) notified. Resident was transported to ER in ambulance."

The After Visit Summary from the ER, dated 03/25/2024, indicated Resident 1 was seen for a fall and diagnosed with a closed head injury.

On 06/06/2024 at approximately 2:00 p.m., Surveyor interviewed Director A. Director A told Surveyor s/he just started his/her position on 05/15/2024 and was not familiar with this incident. Director A said, "Wheelchairs are made for pushing and walkers are made for walking." Director A called Operations Manager (OM) G and placed him/her on speaker phone. Surveyor asked if OM G was familiar with this incident and if there was any follow-up or investigation into why Caregiver E pushed Resident 1 while Resident 1 was seated in his/her walker. OM G told Surveyor it did not ring a bell. S/he said staff were trained upon hire on how to properly transfer

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people. OM G told Surveyor Administrator B, who also the registered nurse, would have more information. Director A called Administrator B and placed Administrator B on speaker phone. Surveyor asked Administrator B if s/he was familiar with this incident. Administrator B said s/he was not as this facility was not in his/her region at that time. Administrator B advised Surveyor to talk to Director H as s/he was helping to cover this facility while Caregiver F was training.

On 06/10/2024 at approximately 11:00 a.m., Surveyor interviewed Director H. Director H told Surveyor that s/he did not start covering at this facility until April 2024, after this incident occurred. Director H told Surveyor s/he was aware of the incident after it occurred as Resident 1 was moving to a different facility. S/he explained to Surveyor Caregiver E pushed Resident 1 while Resident 1 was seated on his/her walker. Resident 1 fell and hit his/her head. S/he was transported to the ER, where CTs (computerized tomography scans) were completed and were negative. Surveyor asked if there was any re-education with Caregiver E on pushing a resident on a walker. Director H told Surveyor s/he was unsure if anyone retrained Caregiver E. Surveyor asked what steps should have been done following this incident. Director H said staff should notify the director, complete the incident report, and notify family. The report should have been signed and sent to the nurse to evaluate for an intervention. S/he said in this case, "why are you pushing someone in a walker?" The intervention would have been to educate the caregiver. Director H said Caregiver F was training to be a director at the time.

On 06/10/2024 at approximately 11:20 a.m.,

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N 388	Continued From page 6 Surveyor interviewed Caregiver F on the phone. Surveyor asked Caregiver F if s/he was aware of this incident. Caregiver F told Surveyor that s/he was, but s/he was on vacation at the time. Surveyor asked if anyone did retraining with Caregiver E to ensure s/he did not push residents in a walker. Caregiver F said s/he planned to discuss at the staff meeting but stepped down from the director position. Caregiver F said s/he was unsure if any re-education was done. The provider did not ensure staff transferred residents properly. Caregiver E pushed Resident 1 while Resident 1 was seated in his/her walker. Resident 1 fell backwards and hit his/her head on the sidewalk. The provider did not ensure staff were re-educated on proper transferring techniques.	N 388		