| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0012898 | A. BUILDING: _____ B. WING _____ | C 06/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY TERRACE STANLEY | 804 PINE ST STANLEY, WI 54768 |

| (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 |
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| N 000 | Initial Comments<br><br>On 6/15/2023, Surveyor conducted a complaint investigation at Country Terrace Stanley. Data collection continued through 06/27/2023.<br><br>The complaint was substantiated.<br><br>Three deficiencies were identified.<br><br>Census: 13 | N 000 | | |
| N 239 | 83.20(2)(a)-(d) Department-approved training courses.<br><br>Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.<br>Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety.<br>First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking.<br>Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. | N 239 | | |

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

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| N 239 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure Caregiver B completed Department approved training.<br><br>Caregiver B did not complete the medication administration Department approved course prior to administering medication on 06/11/2023.<br><br>Findings include:<br><br>The provider is licensed to care for 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, and terminally ill.<br><br>On 05/08/2023, the Department received a complaint alleging residents were unable to receive medications on the overnight shift due to staff not being qualified to give medications.<br><br>On 05/15/2023 at 11:03 AM, Surveyor learned from Assistant Director (AD) C that Caregiver B worked an overnight shift on 06/10/2023 to 06/11/2023 by him/herself. AD C stated Caregiver B was a newer employee but was okay to work by him/herself. AD C stated s/he was not sure if Caregiver B's training was all completed. Surveyor asked AD C if any residents received medication consistently on the overnight shift. AD C stated Resident 3 received a scheduled medication at 12:00 AM and Resident 4 received a scheduled medication at 2:00 AM. AD C stated most PRN (as needed) medications were given by the evening shift before bedtime.<br><br>At 12:30 PM, Surveyor reviewed Caregiver B's record. Caregiver B was hired on 05/27/2023. Caregiver B did not have the Department | N 239 | | |

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| N 239 | Continued From page 2 | N 239 | | |

approved medication administration course completed through the Wisconsin Community-Based Care and Treatment Registry as of 06/15/2023.

The timesheets indicated Caregiver B worked the overnight shift on 06/10/2023, starting at 9:55 PM through 06/11/2023, and ending at 6:06 AM.

At 12:40 PM, Surveyor reviewed Resident 2's and Resident 3's medication administration records (MAR) for 06/10/2023 and 06/11/2023, which indicated the following:

Resident 3 had acetaminophen 500 mg scheduled on 06/11/2023 at 12:00 AM and AD C had initialed the medication was administered.

Resident 4 had carbidopa, levodopa, and entacapone 25-100-20 scheduled on 06/11/2023 at 2:00 AM and carbidopa and levodopa 25-100 scheduled on 06/11/2023 at 2:00 AM and AD C had initialed the medications were administered.

At 12:43 PM, Surveyor interviewed AD C again to clarify why his/her initials were on the paper MAR indicating s/he had given the scheduled medications to Resident 3 and Resident 4 on that overnight shift when only Caregiver B was working. AD C stated s/he had initialed the MAR for Caregiver B when s/he got in at 6:00 AM for the day shift. AD C stated Caregiver B had verbally told him/her the medications had been given by Caregiver B to Resident 3 and Resident 4. AD C stated it was his/her fault and s/he should not have initialed for Caregiver B.

At 2:30 PM, Surveyor interviewed Director A about the above concerns. Director A stated s/he did not know anything about Caregiver B passing

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| N 239 | Continued From page 3<br>medications and would investigate the situation.<br><br>On 06/20/2023 at 6:50 AM, Surveyor interviewed Caregiver D. Caregiver D stated that in April 2023 or May 2023, there was at least one incident where Caregiver D was told by Director A to leave medications out for the overnight shift for untrained staff to pass. Caregiver D stated Director A or other staff would sign for the untrained staff and this usually occurred on the overnight shift.<br><br>On 06/27/2023 at 1:00 PM, Surveyor interviewed Director A. Director A stated s/he was not around that weekend. Director A confirmed Caregiver B worked by him/herself on the overnight shift from 06/10/2023 through 06/11/2023. Director A stated Caregiver B had told him/her s/he did not have a problem working alone and could call if s/he had any issues. Director A stated Caregiver B must have passed the medications that AD C signed out as administered for Caregiver B.<br><br>The provider did not ensure Caregiver B completed the medication administration Department approved training prior to administering medications to Resident 3 and Resident 4 on the overnight shift 06/10/2023 to 06/11/2023. | N 239 | | |
| N 396 | 83.36(1)(a) Adequate staff to meet resident needs.<br><br>The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the | N 396 | | |

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| N 396 | Continued From page 4 | N 396 | | |

provider did not ensure employees were provided in numbers to meet resident needs.

Findings include:

The provider is licensed to care for 16 residents in the client groups terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged.

On 05/08/2023, the Department received a complaint alleging only 1 staff person would be on duty for a shift and there were concerns for resident safety.

On 05/15/2023 at 10:45 AM, Surveyor interviewed Director A about staffing. Director A stated they had been having difficulty finding staff and keeping staff. Director A stated that the typical staffing pattern was 2 staff per shift. Director A stated they usually had an extra staff on day shift. Director A stated that if there were any open shifts that could not be covered, s/he would have to cover them. Surveyor asked Director A if there were any residents that needed 2-person assistance. Director A stated both Resident 1 and Resident 2 needed 2-person assistance with a sit-to-stand.

At 11:03 AM, Surveyor interviewed Assistant Director (AD) C. AD C stated that at times there was only 1 staff on the overnight shift. AD C stated most of the residents did not get up at night. AD C stated s/he agreed to work from 2:00 PM to 6:00 PM on 06/11/2023 alone and split the shift with Director A. AD C stated that on 06/10/2023, Caregiver B worked alone on the overnight shift. AD C confirmed Resident 1 and Resident 2 both needed 2-person assistance. AD C that stated depending upon the day, Resident 4

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| N 396 | Continued From page 5 | N 396 | | |

sometimes needed 2-person assistance as well. Surveyor asked what 1 staff would do if there was an emergency. AD C stated Resident 1 and Resident 2 were point of rescue. AD C stated s/he would call the emergency number and Director A in an emergency and do his/her best to get the residents out of the facility. AD C added the company should not have cut staff hours because they needed the staff at the facility due to resident acuity.

At 12:40 PM, Surveyor reviewed Resident 1's and Resident 2's record.

Resident 1 was admitted on 10/01/2012. The Individual Service Plan (ISP), dated 02/07/2023, indicated Resident 1 used a sit-to-stand to transfer into his/her wheelchair. The ISP stated, "Point of rescue esp (especially) [sic] in bed if fire at night." The resident evacuation assessment, dated 03/10/2023, indicated Resident 1 needed full assistance from 2 staff during most of an evacuation. The resident evacuation assessment indicated Resident 1 may fail to respond to instructions when there is an evacuation. Notes on the resident evacuation assessment written by Director A stated, "A sit to stand is needed if [Resident 1] is in bed and there is a fire. [Resident 1] is a point of rescue if that would occur at night. During the day [Resident 1] is usually up in w/c (wheelchair)."

Resident 2 was admitted on 05/17/2023. The face sheet indicated Resident 2 had diagnoses that included hemiplegia, history of stroke with left sided weakness, epilepsy, and cognitive communication deficit. The pre-admission assessment, dated 04/26/2023, indicated Resident 2 used a walker independently with 1 assist. The June 2023 Kardex indicated Resident

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| N 396 | Continued From page 6<br>2 needed 2-staff assistance with the sit-to-stand and while ambulating with his/her walker. The nurse's notes, dated 05/20/2023 through 06/13/2023, indicated multiple times that Resident 2 was now a 2-person assist.<br><br>At 2:04 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he had worked by him/herself at times but no more than 2 hours at one time until another staff would come in. Caregiver E stated they had recently cut hours, so staff are coming in staggered half hour to one hour, leaving one staff by themselves during that time. Caregiver E stated this had greatly affected resident quality of care.<br><br>At 2:30 PM, Surveyor interviewed Director A. Director A stated s/he did come in frequently to fill in shifts. Director A confirmed at times there was only 1 staff in the facility for a few hours at a time.<br><br>On 06/16/2023 at 2:05 PM, Surveyor interviewed Caregiver F. Caregiver F stated 1 staff came in on an overnight shift at 10:00 PM and the other staff came in on overnight shift at 11:00 PM. Caregiver F stated the 1 staff can be by themselves for about 1 hour at a time.<br><br>On 06/20/2023 at 6:50 AM, Surveyor interviewed Caregiver D. Caregiver D stated one time s/he worked an overnight shift starting at 10:00 PM and the second staff did not come in until 2:00 AM.<br><br>On 06/21/2023, Surveyor reviewed staff timesheets. There were multiple overnight shifts in April, May, and June 2023, that only had 1 staff scheduled at the facility and/or there was only 1 staff on duty for part of a shift. | N 396 | | |

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| N 396 | Continued From page 7<br><br>On 06/27/2023 at 1:00 PM, Surveyor interviewed Director A. Director A stated they started staggering shifts about 1 month ago due to budget cuts. Director A confirmed staff can be alone for a half hour to 1 hour around shift change. Director A stated s/he and AD C have been filling in shifts and s/he might have to start mandating staff. Director A stated s/he was at the facility during the week from about 8:00 AM to 5:00 PM and could help on the floor during that time. Director A stated the timesheets would not reflect when s/he had filled in for open shifts. Director A stated s/he usually wrote on the bottom of the staff schedules but may have forgotten to write it down every time.<br><br>The provider did not ensure employees were provided in numbers to meet resident needs when Resident 1 and Resident 2 required 2-person assistance. There were multiple times when only 1 staff was covering a shift and/or 1 staff was covering for part of a shift. Staff also staggered the start times of their shifts, leaving only 1 staff for a half hour to 1 hour during shift change. | N 396 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any | N 415 | | |

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| N 415 | Continued From page 8<br>PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 3 of 4 resident medication administration records (MAR) were documented accurately.<br><br>Findings include:<br><br>On 06/15/2023, at approximately 2:00 PM, Surveyor reviewed Resident 1's, Resident 3's and Resident 4's paper MARs and found the following medications without documentation (no staff initials):<br><br>Resident 1<br><br>04/28/2023 12:00 PM - Novolog flexpen syringe inject subcutaneously 5 units at lunch<br>06/02/2023 6:00 AM - Levothyroxine 75 micrograms (mcg) take 1 tablet daily<br>06/12/2023 8:00 PM - Terazosin 2 milligram (mg) take 1 tablet daily<br>06/12/2023 8:00 PM - Simvastatin 20 mg take 1 tablet daily<br>06/13/2023 2:00 PM - Acetaminophen 325 mg take 2 tablets 3 times daily<br><br>Resident 3<br><br>06/01/2023 10:00 PM - Acetaminophen 500 mg take 2 tablets every 8 hours<br><br>Resident 4<br><br>04/04/2023 2:00 AM - Carbidopa, levodopa, and | N 415 | | |

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| N 415 | Continued From page 9 | N 415 | | |

entacapone 25-100-20 take 1 tablet 6 times daily
04/04/2023 2:00 AM - Carbidopa and levodopa 25-100 take ½ tablet 6 times daily
04/05/2023 2:00 AM - Carbidopa, levodopa, and entacapone 25-100-20 take 1 tablet 6 times daily
04/05/2023 2:00 AM - Carbidopa and levodopa 25-100 take ½ tablet 6 times daily
05/16/2023 10:00 AM - Sertraline HCL 25 mg take ½ tablet daily
05/16/2023 10:00 AM - Polyethylene glycol take 17 grams (gm) daily
05/16/2023 10:00 AM - Meloxicam 7.5 mg take 1 tablet daily
05/16/2023 10:00 AM - Lisinopril 2.5 mg take 1 tablet daily
05/25/2023 6:00 AM - Amlodipine besylate 2.5mg take 1 tablet daily
05/25/2023 6:00 AM - Lorazepam 0.5 mg take 1 tablet 3 times daily
05/25/2023 6:00 AM - Carbidopa, levodopa, and entacapone 25-100-20 take 1 tablet 6 times daily
05/25/2023 6:00 AM - Carbidopa and levodopa 25 -100 take ½ tablet 6 times daily
05/26/2023 6:00 AM - Carbidopa, levodopa, and entacapone 25-100-20 take 1 tablet 6 times daily
05/26/2023 6:00 AM - Carbidopa and levodopa 25 -100 take ½ tablet 6 times daily
05/26/2023 6:00 AM - Lorazepam 0.5 mg take 1 tablet 3 times daily
05/26/2023 6:00 AM - Amlodipine besylate 2.5mg take 1 tablet daily
05/28/2023 6:00 PM - Quetiapine fumarate 50 mg take 1 and ½ tablets daily
06/01/2023 2:00 AM - Carbidopa, levodopa, and entacapone 25-100-20 take 1 tablet 6 times daily
06/01/2023 2:00 AM - Carbidopa and levodopa 25-100 take ½ tablet 6 times daily

On 06/27/2023 at 1:00 PM, Surveyor interviewed Director A about staff not documenting

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| N 415 | Continued From page 10<br>medication administration in the MARs. Director A stated staff had been "slacking" and s/he had re-educated at the last staff meeting. Director A confirmed they currently do not have an audit system to review resident MARs.<br><br>The provider did not ensure Resident 1's, Resident 3's, and Resident 4's MARs were documented accurately when staff did not initial 25 scheduled medications to indicate if they were given or not. | N 415 | | |