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 02/08/2024

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 02/06/2024, Surveyor conducted complaint investigations, a self-report investigation, and a verification visit. Data was reviewed through 02/08/2024. Two deficiencies were identified. One of 2 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 27	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that each resident with a significant change in their condition had their legal decision maker notified of that change. This was discovered for 2 of 2 residents that became symptomatic and tested positive for coronavirus disease with severe acute respiratory syndrome (SARS CoV or COVID). Findings include:	N 169		

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

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N 169	Continued From page 1 On 01/03/2024, the department received a complaint alleging the family and power of attorney (POA) of a resident was not notified of a significant change in a resident's physical health. On 02/06/2024, Surveyor reviewed the medical records of Resident 5 and Resident 6. There was no notation in the record that Activated POA (APOA) L or Family Member M were notified of the positive test results for COVID and were symptomatic. On 02/06/2024 at 2:37 PM, Surveyor interviewed Assistant Director (AD) K. AD K indicated s/he did not make calls to the POAs of the residents, and s/he would delegate staff to make the calls. AD K stated s/he did not recall who was delegated the calls. AD K stated s/he did not know who made the calls and stated this is why staff must document their contacts and calls. AD K stated the regional nurse was the person who called the Department of Public Health. On 02/07/2024 at 1:26 PM, Surveyor interviewed APOA L. APOA L stated s/he was never called about Resident 5's and Resident 6's illnesses and positive test. APOA L stated s/he heard about Resident 5 having COVID from another visitor. APOA L stated s/he and Family Member M were planning to visit Resident 5 and Resident 6 but did not because of the COVID. APOA L stated s/he found out about Resident 6 testing positive the next week when Resident 6 told APOA L him/herself. APOA L stated no one called him/her or Family Member M about their parents coming down with COVID.	N 169		

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N 352	Continued From page 2	N 352		
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 observation, interview, and record review, the provider did not give each resident their medications as prescribed by their physician. Resident 5 was not given 2 medications for a month. This was discovered for 1 of 2 residents that part of a medication error. Findings include: On 10/04/2024, the department received a self-report that Resident 5 had not received 2 medications for 25 days. The report indicated that on 09/28/2023 it was discovered that Resident 5 was not receiving 2 of his/her medications since 09/03/2023. On 02/06/2024, at 2:54 PM, Surveyor interviewed Assistant Director (AD) K. AD K had submitted the self-report. AD K stated that originally the family said a staff member told them Resident 5 did not get any of his/her medication for the month of September. AD K stated it was 2 medications, mirtazapine and tamsulosin. Mirtazapine is an antidepressant and tamsulosin is for the effects of an enlarged prostate. AD K stated s/he was unable to determine how the errors happened and why it went almost a month without being addressed. AD K stated this is the	N 352		

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N 352	Continued From page 3 responsibility of staff that pass medication. AD K stated all s/he got from the interviews with the staff involved was "a whole bunch of I don't knows." AD K did not recall what Resident 5's primary medical prescriber said about the omissions and was unable to locate a copy of the fax. AD K stated vital signs were taken afterward for a few days. On 10/20/2023 Administrator A, who is also a registered nurse, retrained all the staff that pass medications on what constitutes a medication error and what to do about it, among other topics to consider when passing medications.	N 352		