STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016105	A. BUILDING: _____ B. WING _____	R-C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA ASSISTED LIVING PULASKI	380 CREST DR PULASKI, WI 54162

(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 07/19/2023, with information gathered through 08/02/2023, Surveyors conducted a verification visit, standard survey, 2 complaint investigations and 2 self report reviews. All previous citations were corrected. One (1) of 2 complaints were substantiated. As a result of the survey, 1 deficiency was issued. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 34	{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 immediately notify the resident's legal representative after a fall for 1 of 1 (Resident 1) resident reviewed. Resident 1 had a fall on 08/25/2022. Resident 1's HCPOA (Health Care Power of Attorney) was not notified of the fall until 08/28/2022 when Resident 1 complained of severe pain and required	N 169		

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

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N 169	Continued From page 1 medical attention at the ER (Emergency Room). Findings Include: On 04/24/2023, the department received a complaint regarding falls. On 07/19/2023, Surveyor made an onsite visit to investigate the complaint. A sample of residents was selected, including Resident 1. Surveyor reviewed Resident 1's closed resident record. Resident 1 was admitted to the facility on 04/12/2022 with diagnoses to include hypothyroidism, hyperlipidemia, atherosclerotic heart disease and atrial fibriliation. Resident 1 passed away on 09/03/2022. A facility fall report dated 08/25/2022 indicated Resident 1 had an unwitnessed fall. The report stated, "Staff heard a crying from down [his/her] hallway when staff entered room staff noticed resident on the ground staff took vitals range of motion and pain resident stated [s/he] didn't hit [his/her] head staff assisted resident back to bed." Additionally, the report indicated resident's explanation was "Resident stated that [s/he] was trying to stand up. And fell." The report continues to state the physician, resident's family/representative, facility staff and other providers were not notified of the fall. An observation note dated 08/28/2022 written by Executive Director A stated, "...writer was updated by med passer that resident was in severe pain; tensing up and crying out in pain. Writer told med passer that I would contact son [POA] and has [sic] if [s/he] wanted [him/her] sent out since APAP [tylenol] was all [s/he] had for PRN [as needed]. Writer was unable to reach son. RN	N 169		

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N 169	Continued From page 2 [Registered Nurse] then called writer to inform [him/her] that resident had fallen on the 25th and was not updated about this. Writer was also not updated about the fall..." On 07/19/2023 at 2:45 P.M., Surveyor interviewed Executive Director A. Executive Director A stated at the time of Resident 1's fall on 08/25/2022, s/he was on vacation. Executive Director A stated s/he was not informed of fall and did not update family after the fall occurred. Executive Director A stated she did receive a voicemail from Resident 1's POA wondering why s/he was not called about the fall. On 07/20/2023 at 10:50 A.M., Surveyor interviewed POA-C. POA-C verified s/he was the POA for Resident 1. POA-C stated s/he was unaware of any fall on 08/25/2022 until 08/28/2022 when s/he arrived at the hospital. POA-C stated hospital staff made him/her aware of the fall. POA-C stated s/he spoke with Executive Director A and questioned why s/he was not notified of the fall. Executive Director A told POA-C s/he was on vacation and was not made aware of the fall.	N 169		