STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017149	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA ASSISTED LIVING	1900 HUCKLEBERRY AVE OMRO, WI 54963

(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 A complaint investigation was conducted at Country Villa Assisted Living on 05/06/2025. As a result of this survey the complaint was substantiated with 1 deficiency identified. Census: 33	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 staff, family, and resident interviews the provider did not ensure 1 out of 1 resident reviewed received medications as prescribed by a practitioner. Resident 1 did not receive scheduled Glipizide 10 mg daily from 10/03/2024 through 10/23/2024 as ordered resulting in a high blood sugar of 384 and being sent to the ER (Emergency Room). Findings include: On 05/06/2025, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 09/19/2023 with diagnoses of diabetes mellitus,Type 2., chronic kidney disease stage IV, atrial fibrillation, and congestive heart failure. The Physician's order sheet for Resident 1 dated 09/02/2024 showed an order for Glipizide ER 5 mg daily for diabetes. On 09/17/2024, a doctor's	N 352		

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

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N 352	Continued From page 1	N 352		

order said, "Blood sugars have increased significantly in the last 6 months with A1C up to 8.9. I would recommend increasing Glipizide to 10 mg. Other labs are stable." The order noted it had been faxed to the pharmacy on 09/18/2024. Noted. Pending delivery. The new order read Glipizide ER 5 mg oral tablet extended release 24 hour. Take 2 tablets by mouth daily.

A review of Resident 1's MAR (Medication Administration Record) for October 2024 showed the order was on the MAR to give Glipizide ER tab 5 mg. Take 2 tablets by mouth once daily (9 am). The medication was marked as given to Resident 1 on 10/01/2024 and 10/02/2024 and then not again until 10/24/2024. Glipizide was not marked as given from 10/03/2024 through 10/23/2024.

During an interview with Surveyor on 05/06/2025 at approximately 11:00 AM, DIR (Director) - A confirmed Resident 1 had not received Glipizide as ordered in October 2024. DIR - A indicated the facility's nurse had left and DIR - A was doing meds. DIR - A thought the Glipizide card with 2 pills in was in error as s/he knew Resident 1 only got 1 pill each AM. DIR - A said s/he sent the card back to the pharmacy thinking it was in error but it wasn't. DIR - A confirmed one morning Resident 1's blood sugar was 384 so s/he was sent to the ER. There was no adjustment to the Glipizide order at the ER and Resident 1 returned the same day.

The ER (Emergency Room) note dated 10/23/2024 showed Resident 1 was treated for fatigue, given his/her hyperglycemia and chronic kidney disease. Indication noted Resident 1 may have been mildly dehydrated. Assessment did not require hospital admission. Resident 1 was

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N 352	Continued From page 2 sent to the ER at 10:07 AM and returned to the facility at 2:20 PM. During an interview with Surveyor on 05/06/2025 at approximately 12:30 PM, Resident 1 indicated s/he did not get his/her Glipizide last October for at least 19 days and his/her blood sugar went to almost 400. Resident 1 indicated MT (Med Tech) - C "caught it as I was hard to wake up. They sent me to the ER because my blood sugar was high but they really didn't do anything at the ER but just send me back when my blood sugar was under 200." Resident 1 indicated before this incident, blood sugars were checked about monthly but after this, they were checked initially 3 times a day, and recently back to 3 times a week. Resident 1 indicated s/he is not on insulin and not on a diabetic diet but knows what not to eat. Resident 1 said FMBR - D had all his/her meds on his/her phone. After s/he got back from the ER, FMBR - D and MT - C reviewed Resident 1's MAR and found the error that Glipizide had not been given as ordered from 10/03/2024 through 10/23/2024. DIR - A called and got it ordered again. FMBR - D confirmed the facility still wasn't aware the Glipizide hadn't been given upon return from the ER. FMRB - D said MT - C helped him/her review Resident 1's orders and the error was found. In an interview with Surveyor on 05/06/2025 at approximately 1:00 PM, RD (Regional Director) - B and DIR - A confirmed Resident 1 did not receive his/her Glipizide 10 mg as ordered from 10/03/2024 through 10/23/2024 (21 days). RD - B indicated the incident was reviewed with DIR - A and a discipline was issued.	N 352		