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 _____	C 05/13/2026

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 05/05/2026, Surveyor conducted a complaint investigation at Country Villa Assisted Living Pulaski. Additional information was gathered through 05/13/2026. The complaint was substantiated, and 3 deficient practices were identified. Census: 32	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 1 had adequate supervision to meet his/her needs. Resident 1 had a documented history of behaviors including elopements and was discovered missing from the facility 3 times within 11 days. Findings include: The provider is licensed to serve up to 38 residents who may have diagnoses including advanced age, physical disability, irreversible	N 426		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 426	Continued From page 1	N 426		

dementia/ Alzheimer's disease, and/ or emotionally disturbed/ mental illness.

On 05/05/2026, Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 02/09/2026 with diagnoses including dementia, anxiety and hypertension. Resident 1 had an activated Power of Attorney for healthcare (POA) C. Resident 1 was assessed upon admission as requiring safety checks every 15 minutes for wandering behavior. Resident 1 was discharged from the facility on 04/13/2026.

On 05/05/2026 at 8:30 AM, Surveyor interviewed POA C. POA C stated Resident 1 had a history of elopement that was clearly communicated with the provider during the admission assessment. This was reflected within the admission assessment noting Resident 1 required 15-minute safety checks for wandering behavior. POA C stated s/he was aware some attempts to elope occurred when Resident 1 was first at the facility but that medications were being increased as an intervention and needed time to take full effect. POA C stated it was not until a meeting on 04/06/2026 that the provider notified him/her that Resident 1 had been "eloping on a weekly basis." POA C stated the meeting on 04/06/2026 was held by Administrator A who issued the resident a 30-day discharge notice with the only other option being the family to provide 24 hour 1:1 supervision. POA C stated the only interventions provided were medication increases that had yet to take full effect and 15-minute checks that had been in place since admission. POA C stated s/he was not immediately notified about elopements that occurred on 03/23/2026 or 03/30/2026.

On 05/05/2026 at 11:30 AM, Surveyor interviewed

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N 426	Continued From page 2 Administrator A. Administrator A stated Resident 1 was given a 30-day discharge from the facility notice on 04/06/2026 after multiple attempts and elopements occurred. Administrator A stated the provider utilized interventions such as the use of delayed egress doors, sign placement by exits, medication changes, and 15-minute checks to mitigate Resident 1's behavior prior to issuing the 30-day notice. Administrator A was unaware the circumstances in which Resident 1 was issued an involuntary discharge did not meet the Chapter 83 code requirements and that the provider was responsible for providing behavior management and supervision necessary to meet the resident's needs. On 05/05/2026 at 12:00 PM, Surveyor interviewed Administrator A while reviewing notes and incident reports for Resident 1's elopements. Administrator A stated the delayed egress system would alarm when someone pushed on the door to be let out for 15 seconds before the door would open. Administrator A stated once the door closed, the alarm would stop. Administrator A stated the expectation was when caregivers heard the alarm they would communicate via walkie talkies to let others know the door that alarmed was checked. Administrator A acknowledged if caregivers were busy assisting other residents, they may not hear the alarm or be able to respond. On 05/05/2026, Surveyor reviewed Resident 1's observation notes and incident reports. Resident 1 was documented as having exit seeking behavior on 02/09/2026, 02/12/2026, 02/14/2026, 02/15/2026, 03/03/2026, 03/05/2026, 03/23/2026, 03/26/2026, 03/29/2026, 03/30/2026, and 04/03/2026. Resident 1 eloped from the facility on 03/23/2026, 03/30/2026, and 04/03/2026.	N 426		

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N 426	Continued From page 3 The incident report for the elopement on 03/23/2026 noted Resident 1 was discovered outside on the sidewalk at 1:12 PM. The report noted the Resident 1 came back inside and told Caregiver J "it was so cold outside." No further details or approximation of amount of time the Resident was outside was noted. The report noted POA C was not updated until the next day at 8:30 AM. The temperature outside was approximately 35 degrees Fahrenheit. (Retrieval date 07/20/2026, https://www.accuweather.com/en/us/pulaski/54162/march-weather/34507?year=2026.) The incident report for the elopement on 03/30/2026 noted Resident 1 was found by another resident's visitor in the parking lot of the facility at 1:15 PM. There was no detail included estimating the last time s/he had been seen prior to being discovered by the visitor. The temperature outside was approximately 54 degrees Fahrenheit. (Retrieval date 07/20/2026, https://www.accuweather.com/en/us/pulaski/54162/march-weather/34507?year=2026.) During the interview on 05/05/2026 at 12:00 PM with Administrator A, s/he could not state how long Resident 1 was outside but stated all 15-minute checks were documented as completed by staff. Administrator A stated the staff did not hear an alarm go off and supposed a visitor may have let the resident out of the facility. The provider had the keypad locks recoded and stated they no longer gave the passcode out to family members. Administrator A acknowledged they did not know for sure if someone let Resident 1 out on 03/30/2026, and it was possible the caregivers did not hear or respond to the alarm. An incident report for the elopement on	N 426		

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N 426	Continued From page 4 04/03/2026 noted Resident 1 was found by an off duty staff member approximately 1 block away from the facility on a side street that had no sidewalk and near a county highway which had regular traffic.The temperature outside was approximately 40 degrees Fahrenheit. (Retrieval date 07/20/2026, https://www.accuweather.com/en/us/pulaski/54162/april-weather/34507?year=2026.) During the interview on 05/05/2026 at 12:00 PM with Administrator A, Administrator A stated s/he received a call from the staff member (Caregiver J) who found Resident 1 at approximately 3:58 PM. Administrator A stated s/he called Lead Caregiver K who was working and asked if s/he knew where Resident 1 was. Lead Caregiver K told Administrator A s/he last saw Resident 1 in the facility approximately 5-7 minutes ago. Administrator A stated when s/he asked staff what happened s/he was told by Lead Caregiver K that no one heard the alarm go off. On 05/05/2026 at 12:30 PM, Surveyor interviewed Administrator A. Administrator A reviewed the door alarm would sound for 15 seconds and then once the door closed, the alarm would stop. Administrator A acknowledged a delayed egress or alarm system is not intended to supplement caregivers supervision, and Resident 1 was able to elope when no caregiver was present to hear and respond to the alarm that only sounded for a span of approximately 18 seconds. The supervision provided was not enough to meet Resident 1's safety needs as s/he was able to elope 3 times in 11 days. Administrator A confirmed s/he was aware Resident 1 required additional supervision and stated that was the reason the provider determined Resident 1 needed to either have 1:1 supervision or be involuntary discharged.	N 426		

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	0016105	A. BUILDING: _____ B. WING _____	C 05/13/2026

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

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N 426	Continued From page 5 Administrator A reviewed the admission agreement stated the provider would meet the resident's supervision needs. Administrator A acknowledged there was no provision within the admission agreement noting the provider was unable to provide 1:1 care for resident's who were assessed as requiring it. Cross Reference N0654 DHS 83.59(4)(f) Delayed Egress: Department Approval	N 426		
N 654	83.59(4)(f) Delayed egress: department approval Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: To obtain department approval, the CBRF shall demonstrate that delayed egress equipment is necessary to ensure the safety of residents served by the CBRF, specifically persons at risk of elopement due to behavioral concerns, cognitive impairments or dementia, including Alzheimer ' s disease. This Rule is not met as evidenced by: Based on record review and interview, the provider did not receive approval for the use of delayed egress. Findings include: The provider is licensed to serve up to 38 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/ or emotionally disturbed/ mental illness. The facility	N 654		

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N 654	Continued From page 6 was licensed in 2016. On 05/05/2026, Surveyor observed the facility had 7 exits that were equipped with delayed egress equipment. On 05/05/2026 at 12:00 PM, Surveyor interviewed Administrator A. Administrator A stated there was a day within the last month (dated unknown) when one of the facility exit doors (North West corner) that is equipped with a delayed egress was not functioning and required replacement. When asked to review the required Department and Office of Plan Review and Inspection (OPRI) approvals for the delayed egress systems, Administrator A gave Survey a copy of correspondence between Licensee D and OPRI between 06/01/2018 and 08/21/2018. Both letters from OPRI (dated 08/05/2018 and 08/12/2018) noted approval for the use of delayed egress equipment needed to be obtained by the provider by contacting the Department. No records to verify Department approval and OPRI approval of the use of the delayed egress equipment on 7 doors were provided. On 05/06/2026 at 12:00 PM, Surveyor conducted an exit interview with Administrator A and Licensee D. Licensee D confirmed there was no other documentation to review and acknowledged s/he needed to retroactively seek approval from the Department and OPRI for use of the delayed egress system. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 654		

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	0016105	A. BUILDING: _____ B. WING _____	C 05/13/2026

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

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Y3244	Continued From page 7	Y3244		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received adequate assessment, notification, and care for an observed skin concern. Staff (Caregivers E, F, G, and H) documented reporting to the provider 5 times that Resident 1 had reddened skin folds and the provider did not ensure the resident received a medical assessment or treatment, or that his/her medical provider and Power of Attorney for healthcare (POA) C were notified. Findings include: The provider is licensed to serve up to 38 residents who may have diagnoses including advanced age, physical disability, irreversible	Y3244		

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Y3244	Continued From page 8	Y3244		

dementia/ Alzheimer's disease, and/ or emotionally disturbed/ mental illness.

On 04/22/2026, the Department received a complaint alleging resident's care needs were not being met.

On 05/05/2026, Surveyor reviewed Resident 1'a record and noted s/he was admitted to the facility on 02/09/2026 with diagnoses including dementia, anxiety and hypertension. Resident 1 had an activated Power of Attorney for healthcare (POA) C. Resident 1 required prompting to use the bathroom and required staff to apply barrier cream to prevent skin breakdown from incontinent episodes.

On 05/05/2025 at 11:00 AM, Surveyor interviewed Administrator A who was a licensed Registered Nurse and able to provide a skin assessment. Administrator A stated if a caregiver noticed a change in condition they were expected to document their observations in the observation notes, communicate between shifts during report to other shifts and alert the on-call Wellness Coordinator B or Administrator A for any concerns. Administrator A stated s/he and Wellness Coordinator B were responsible for regularly reviewing resident observation notes and if a change in condition occurred or health monitoring was needed, s/he would perform an assessment of the resident.

On 05/05/2026 at 8:30 AM, Surveyor interviewed POA C. POA C stated on 04/09/2026 s/he assisted Resident 1 with a shower and observed redness and yeast irritation under his/her chest folds and groin. POA C stated s/he had not been informed that Resident 1 was having issues with his/her skin and was upset to find that nothing

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Y3244	Continued From page 9	Y3244		

had been done, including no assessment or treatment, and nothing had been communicated to him/herself or Resident 1's medical provider.

On 05/05/2026, Surveyor reviewed Resident 1's record. On 02/11/2026 Administrator A conducted a skin assessment of Resident 1 and noted, "No areas of concern noted ..." Surveyor reviewed Resident 1's observation notes and discovered on 03/06/2026, 03/22/2026, 03/26/2026, 03/27/2026, and 04/04/2026 caregivers (Caregivers E, F, G, and H) noted Resident 1 had redness under his/her chest folds and redness under his/her abdominal fold on 03/26/2026. Each noted included either the "on call" or Wellness Coordinator B was notified.

On 05/05/2026 at 1:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was unaware of any specific change in condition related to Resident 1's skin and that had s/he been reported to, s/he would have performed an assessment. Administrator A stated s/he had no recollection or documentation of an assessment for redness being completed by him/herself as a licensed RN. Upon review of the observation notes Administrator A stated the staff had been monitoring the redness but could not find any documentation or order to suggest the concernwas assessed, treated, or that the medical provider or POA C were notified about the change.

On 05/05/2026 at 2:00 PM, Surveyor interviewed Wellness Director B. Wellness Director B stated s/he was aware staff reported Resident 1 had redness under his/her skin fold but could not recall if s/he reported it to Administrator A, Resident 1's physician, or POA C.

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Y3244	Continued From page 10 On 05/06/2026 at 10:00 AM, Administrator A noted in an e-mail to Surveyor: "In regards to the redness there are observation notes from staff regarding redness under [his/her] [chest folds] and also one regarding redness under [his/her] abdominal folds. This was being monitored via documentation and staff reports. There is not an additional note from myself or [Wellness Director B] due to the redness not being persistent, no open skin, no moisture, and no yeast reported. Redness is common due to skin to skin contact in overweight individuals. Resident did not always wear a [supportive top] and was always active throughout the building. Staff reports resident would occasionally place [supportive top] on [him/herself], and some of the [supportive tops] were tight. There were also a few instances of resident refusing personal cares to be completed." On 05/06/2026 at 12:00 PM, Surveyor conducted an exit interview with Administrator A and Licensee D. Surveyor reviewed that the redness was persistent as it was concerning enough that staff documented and reported it 5 times between 03/06/2025 and 04/04/2025. Administrator A acknowledged, because the redness could be due to various reasons, because redness is common for Resident 1's body type, and because the staff were not licensed to assess the resident, an assessment was needed by a licensed person. On 05/06/2026 2:39 PM, Administrator A e-mailed Surveyor noting that no other documentation or orders regarding efforts to address the reported skin redness were found.	Y3244		