STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulder Health Care Facility	713 Leonard St N West Salem, WI 54669

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39713 Based on observation, interview, and record review, the facility did not ensure that each resident received adequate supervision to prevent accidents for 1 of 3 residents reviewed for needing assistance or supervision with meals. On 10/13/24, R1 was in the dining room for her supper meal. R1 was attempting to eat soup and spilled the soup onto herself causing 2nd degree burns to her right arm and abdomen. R1 required supervision during meals; supervision and assistance were not provided. Soup temperature following R1 suffering burns and after meal service was 177 degrees. The facility's failure to provide adequate supervision and assistance during meals and the failure to ensure foods and fluids were served at a temperature that would not cause burns created a finding of immediate jeopardy which began on 10/13/24. Nursing Home Administrator (NHA) A was notified of the immediate jeopardy on 10/30/24 at 9:30 AM. The immediate jeopardy was removed on 10/30/24; however, the deficient practice continues at a scope/severity of E (Pattern/Potential for Harm) as the deficient practice has the potential to affect 20 residents that need assistance with meals while the facility implements its removal plan. Evidenced by: The facility policy titled Hot/Liquid Food Management dated 1/2024, states, in part: Policy: It is the policy of this facility to manage resident consumption of hot liquids in order to prevent burns or serious injury. Procedure: 1. A Hot Food / Liquid Assessment will be performed upon admission, quarterly and with a resident significant change in condition by a facility clinical leader, and if needed in collaboration with Occupational Therapy. 4. Residents identified through the assessment process as at risk for injury related to exposure to hot liquids shall not be left unsupervised during meal service while pending completion of evaluation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

5. Intervention selections will be communicated with nursing, dietary staff, activity staff and updated on resident plan of care.

6. Residents identified as at risk will have selections listed on diet card in addition to an indicator Hot Spill Risk to alert staff during delivery of meal is at high risk for burn injury.

7. The individual resident care plan will reflect resident specific risk factors and appropriate interventions to assist in preventing burn injuries.

8. The dietary department will monitor hot food/beverage temperatures on the tray line on a daily basis to ensure appropriate temperatures are maintained.

Subject: Identify Resident at risk for burns caused by hot liquids.

Purpose: To reduce the risk of Residents burns related to hot beverages, liquids and foods, and to provide guidance on re-heating resident foods and/or liquids as well as provide guidance on steps to take if a burn occurs.

Standard of Practice:

- Hot liquids are not to be served at a temperature greater than 135 degrees F (Fahrenheit), unless care plan has specific identified alternatives.

- Clothing protectors or cloth napkins will be available and offered to all residents during mealtime or when Hot Liquids or foods are served.

- Dining room service will be supervised.

- Resident at high risk will require 1 to 1 supervision.

Procedure:

3. Maximum temperature at point of service should not exceed 135 degrees.

5. Residents who have liquid spills will receive lids with sippy openings and a clothing protector or cloth napkin as a temporary intervention until evaluated by Occupational Therapy. All hot liquids will be placed in insulated mugs with lids including soups. Care plan and diet cards will be updated as needed.

The table below, from the State Operations Manual, shows the estimated time for a person to receive third degree burns at various temperatures.

155 F/68 C - 1 second

148 F/64 C - 2 seconds

140 F/60 C - 5 seconds

(continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	133 F/56 C - 15 seconds 127 F/52 C - 1 minute 124 F/51 C - 3 minutes 120 F/48 C - 5 minutes R1 was admitted to the facility on [DATE] and has diagnoses that include in part: cerebral infarction, aphasia, weakness, dysphagia, diabetes mellitus type 2, traumatic hemorrhage of left cerebrum, and hemiplegia and hemiparesis affecting right dominant side. R1's Quarterly Minimum Data Set (MDS) Assessment, dated 8/10/24, staff assessment of R1's cognitive status indicates R1 is moderately impaired with short- and long-term memory. Section GG shows that R1 has impairment to one side of upper and lower extremity. R1 has a mechanically altered diet needing supervision/touch assistance. R1's care plan states, in part: Problem: Problem Start Date: 11/27/22. Category: Nutritional Status Hot food/liquid assessment. Approach Start Date: 11/27/22. At risk-Encourage clothing protector or cloth napkin over the lap and chest when consuming hot food/liquids, cup with lid, inner lip plate, consume all hot liquids/food at table. Problem: Problem Start Date: 8/30/22. Category: ADLs (activities of daily living) Functional Status/Rehabilitation Potential Alteration in ADLs-self care deficit r/t (related to) Resident's participation and functioning level does vary/fluctuate. Approach Start Date: 10/25/24. Place all soups in coffee mugs. Approach Start Date: 11/17/22. Status of eating ability: Assist of 1 when she allows, refuses assistance often. Eats with her hands/fingers, refuses silverware often. Problem: Problem Start Date: 2/9/22. Category: Nutritional Status R1 is at Nutritional / Hydration risk d/t PMH (past medical history) of cerebral infarct w/ (with) l (left) side hemiplegia, dysphagia, aphasia, malnutrition, DM (diabetes mellitus), hyperkalemia, AKF (acute kidney failure). Approach Start Date: 2/9/22. Assist with meals as needed. Refuses assistance often, eats with her fingers and hands. Refuses silverware often. Approach Start Date: 2/9/22. Diet: Regular with chopped textures and thin liquids. Plate guard for all meals. Cut solid foods into bite sized pieces to discourage impulsively large bites. Receives lidded cups with all meals to prevent spilling. Staff provide PRN (as needed) assistance with meals. The facility document titled, Hot Food/Liquid Assessment, dated 8/18/24, states in part: Type of Assessment: Quarterly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Clinical Risk Review: Yes is answered for the following questions . does the resident have poor hand control; does resident have dementia, impaired cognition, or confusion; does resident have dx (diagnosis) of Parkinson's, CVA (cerebral vascular accident), multiple sclerosis, seizure disorder, left sided or right sided weakness; does resident have frequent impulsive acts/short tempered or behavior concerns; does resident have contractures to hands/fingers/elbows present; does the resident have any history of accident/injury with the use of hot liquids or foods. If any of the questions are answered with a Yes, STOP! The resident is considered to be high risk for possible management of hot foods or fluids that could place them at risk for injury. Select all appropriate intervention(s) that will reduce the resident risk. Resident's preferences are to be taken into consideration with selections. Those marked as interventions include . cup with lid, cup 1/2 (half) full, consume hot liquids/food while sitting at table only, clothing protector or cloth napkin over lap & (and) chest, scoop plate, staff to provide assistance with meal with hot foods or liquids. On 10/29/24, at approximately 8:45 a.m., Surveyor reviewed R1's meal ticket that is placed on the resident's tray when meal is sent out to be served. Meal ticket indicates R1 needs PRN assist with meals. Lids with beverages. Regular, Chop. Preferences: Cut up food into bite-sized pieces; Coffee, Juice; Cup with lid (1 each); Inner lip plate (1 each). Of note: Surveyor observed R1 during breakfast and lunch on 10/29/24. R1 was noted to not have cups with a lid or an inner lip plate during either meal service. Nurses Note from 10/13/24 at 6:08 PM, states, Resident was eating in the dining room and this writer heard uncomfortable screaming. Immediately went to dining room where resident was screaming. Observed soup all over resident's lap on right side, observed inflammation and redness to right arm. Asked resident if she spilt her soup and she said yes. Took resident to her room for further skin assessment and removal of clothing. Observable blisters and fluid form. Resident screaming in pain, grabbing at right arm. Cold compress immediately applied to areas. On call MD (medical doctor), and POA (power of attorney) was called and wanted her to go to the ER (emergency room). DON (director of nursing) notified of event. Hospital ER note from 10/13/24, states in part, Significant 2nd degree burns, recommended consult with burn center. ER was unable to clear answer if the facility could manage the wounds so the burn center accepted her for transfer. Wounds covered with saran wrap, oxy (pain medication) given, IV (intravenous) bolus of 500 mL (milliliters), tetanus update, and basic blood work. Transferred to [hospital name] burn unit. IDT note from 10/14/24 at 12:06 PM, states, Resident obtained burns to right hand/forearm and abdomen on 10/13/24 at approximately 1705 (5:05 PM). Resident was sitting in the dining room for dinner, and spilled soup onto self. Redness and fluid filled blisters noted to area immediately following. Wound edges irregular. No bleeding or drainage noted. Cool compress immediately applied to area. Resident sent to ER for evaluation. New orders received from OT to assess self-feeding upon return to facility. R1 returned to the facility on [DATE] with wound orders for . Bacitracin, cuticerin, and gauze, change daily, apply derma fit to right arm and hand. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospital Discharge Summary from 10/15/24 at 0651 (6:51 AM), states in part, Primary Discharge Diagnosis: Burn to abdomen and arms. Presenting Problem/History of Present Illness: Per admission H&P (history and physical), she was eating hot soup and spilled it on herself at dinner today, which was reported per staff. Patient was crying due to pain and developed some blisters on her right abdomen and right forearm. Per the facility she spilled 170 degree soup on herself and sustained 2nd degree burns to the right hand and righ [sic] side of abdomen with blistering. On exam patient is non-verbal and can acknowledge simple questions but not oriented to place or time. She appears non toxic and comfortable. [NAME]-[NAME] Burn Calculation: Total 2nd degree burns 3. TBSA (total body surface area) % burned (2nd) 3. The patient was admitted to the burn unit on 10/13/24 following her burn. She was started on multimodal pain control, a high protein, high calorie diet, bowel regimen, and DVT (deep vein thrombosis) prophylaxis. Initial wound cares and cleansing were completed which the patient tolerated well with appropriate IV (intravenous) and oral analgesia. Wound cares at her facility were arranged and she was discharged on ,d+[DATE] with scheduled follow up in Burn Clinic. Nurse's note from 10/15/24 at 5:35 PM, states in part, Returned to facility via ambulance at 1540 (3:40 PM). BP (blood pressure) 122/79, P (pulse) 82, R (respirations) 18, O2 sat (saturation) 97% (percent) on room air. Dressing and abdominal binder to right arm/hand and abdomen remain in place per orders. No drainage noted. Resident displayed no signs/symptoms of pain/discomfort. Resident currently resting in bed, no behaviors noted. Nurse's note from 10/15/24 at 6:54 PM, (recorded as a late entry on 10/16/24 at 7:00 PM), states in part, Resident re-admits [Hospital Name] with primary diagnoses of scald burn to right arm and right abdomen. She has comorbidities which include the following: stage 3 CKD (chronic kidney disease), atrial fibrillation with RVR (rapid ventricular rate), anxiety with agitation, type 2 diabetes mellitus, cerebrovascular accident, hypothyroidism, and hypertension. She is alert and oriented x (times) 1. Dressing put in place by wound care and are to remain in place until follow up appointment on 10/21/24. Current dressing is Mepilex AG (antimicrobial foam dressing that absorbs exudate and maintains a moist wound) - wound care instructions listed if dressing becomes soiled. She was given a prescription for oxycodone for pain if needed. She continues to be assist of 2 with hoyer lift for all transfers. She continues with a regular diet, chopped up foods. Wound Physician Notes from 10/23/24 state in part, Chief Complaint: Patient present with wound on her right arm; right lower abdomen, left lower abdomen. Additional System: Spilled soup on abdomen and R (right) arm 10/13/24 resulting in burn wounds 10/23/24 cellulitis to Rt (right) arm. Rec (recommend) Keflex 500 mg BID x1 week. Focused Wound Exam (Site1). Burn Wound of the Right Arm Full Thickness. Wound Size: 10 x 5.5 x 0.1 cm (centimeters). Exudate: Moderate serous (clear, thin, watery fluid). Slough: 70%. Slough (a yellow, white, or tan, stringy, or thick material) 10%. Dressing Treatment plan: Primary Dressing(s): Santyl apply once daily for 30 days; Xeroform gauze apply once daily for 30 days. Secondary Dressing(s): ABD (abdominal) pad apply once daily for 30 days; Gauze roll (stretch) 4 (inch) apply once daily for 30 days; Tape (retention) apply once daily for 30 days. Recommendations: Cleanse with saline at time of dressing change; Off-Load Wound; Antibiotic Choice: Keflex 500 mg bid x 1 week for cellulitis. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Focused Wound Exam (Site 3). Burn Wound of the Right, Lower Abdomen Partial Thickness. Wound Size: 8 x 6.1 x Not Measurable cm. Exudate: None. Other viable tissue: 70% (Dermis). Primary Dressing: [NAME] sulfadiazine apply once daily for 30 days: Okay not to cover with secondary dressing. Patient allergic to adhesive tape. Nurse's note from 10/23/24 states, Cephalexin 500 mg (milligrams) BID (twice a day) for 1 week for cellulitis to the right arm. Wound orders from 10/24/24, state in part, Treatment to right arm burn. Area measures: 18 cm (centimeters) x 5.5 cm x 0.1 cm. Dressing: Santyl to wound bed. Cover with Xeroform (non-adherent primary dressing) and ABD (abdominal gauze pad). Secure with Kerlix (sterile gauze) and change daily. On 10/29/24 at 12:30 PM, Surveyor observed Assistant Director of Nursing (ADON) G complete wound care of R1's right arm as the abdomen is healed at this time. Wound care was completed, glove changes, and hand washing and sanitizing were appropriate. Surveyor then observed ADON G put on ordered Santyl directly into her gloved hand and applied it directly from her gloved hand to R1's wound bed. On 10/29/24 at 9:30 AM, Surveyor interviewed Licensed Practical Nurse (LPN) D. Surveyor asked LPN D to describe the details of the incident with R1 on 10/13/24. LPN D stated the incident happened on Sunday during the supper meal. I was at the nurses' station charting when I heard R1 yelling. When I went to the dining room R1 was holding her arm and I noted that her arm was wet. I scanned the table area and only saw an empty cup of grape juice so initially thought that is what R1 had spilled. I took R1 to her room to assess her and found remnants of soup. R1's arm was red, and blisters formed shortly after. Another LPN came into to assist me, and I sent her down to take the temp of the soup R1 was served. LPN D then went down and observed kitchen staff take the temperature of soup which was noted to be 177 degrees Fahrenheit at that time. I updated the MD. The Certified Nursing Assistants (CNAs) assisted with getting R1's clothes off and into bed. We immediately placed cold washcloths to areas on the arm and abdomen. R1's POA was updated and was ok with sending her in. Surveyor asked LPN D if LPN D remembers seeing anyone in the dining room. LPN D stated, I did not see anyone in the dining room. R1 did need feeding assistance. The process changed following incident to have someone with her during meals. R1 also developed cellulitis after returning to the facility and currently is on an antibiotic. Hospital called after R1 was sent out to ask if we could complete the dressing changes. LPN D indicated she called the DON and she said we could do the dressing changes, so I called the hospital back and let them know. R1 did not come back though and ended up in the burn unit in [city name]. R1 is currently receiving daily dressing changes. Surveyor asked LPN D if she remembers seeing R1 wearing any clothing protector or napkins when she entered the dining room. LPN D stated, R1 did not have clothing protector on when I went into the dining room and R1 is not able to remove them on her own. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/29/24 at 11:35 AM, Surveyor interviewed LPN E. Surveyor asked LPN E what she remembers from the incident that happened with R1 on 10/13/24. LPN E stated, LPN D asked if I could come help. R1's arm was quite burned, and cold compresses were applied. The burn was around her thumb and wrist then up the arm/mid arm, a couple of inches above the wrist and a couple of inches below the elbow, as well as the right groin. The areas blistered quickly. I walked away to get washcloths and when I came back the blisters had already formed. Surveyor asked LPN E if she was asked by LPN D to go to the kitchen. LPN E stated, LPN D had asked me to go to the kitchen and have the kitchen staff temp the soup while I watched, which I did, and the soup temperature was 177 degrees. I reported the temperature of the soup to LPN D and she documented it. Surveyor asked LPN E who serves the meals in the dining room. LPN E stated, the kitchen staff gets the trays ready and whoever is assigned to the dining room takes the trays to the residents. Kitchen staff do not serve meals that I am aware of. On 10/29/24 at 1:05 PM, Surveyor interviewed CNA F. Surveyor asked CNA F what type of assistance R1 required in the dining room. CNA F stated, R1 needs help with setup and clothing protector because she spills a lot. Surveyor asked CNA F if she was in the dining room when incident occurred. CNA F stated, I may have been in the dining room, but I think we were done passing trays. I was on the 100 wing that day and we didn't have any residents that were dependent for meal assistance. On 10/29/24 at 1:15 PM, Surveyor interviewed CNA J. Surveyor asked CNA J what the fork and knife the fork and knife next to a person's name on the staff schedules indicate. CNA J stated, means you are to go the dining room and pass trays but can switch with person you are working with. Those that need supervision or assist are fed last or someone will stop passing trays and sit and assist. R1 can feed herself but needs supervision after setup. As far as I know R1 was able to use left hand for anything she needed. On 10/29/24 at 11:45 AM, Surveyor interviewed CNA H. Surveyor asked CNA H if she was in the dining room at the time of R1's incident on 10/13/24. CNA H stated, I was not in the dining room when R1 got burned. I was helping another resident, and I went down the hall to ask where R1 was. When I got down the hall EMS (emergency medical services) were already here and I helped get R1 on the cot, but that was all. Surveyor asked CNA H if she saw R1's burns. CNA H stated, I saw the burn on the lower part of her arm by the wrist. The skin was peeling and blistered. Surveyor asked CNA H what type of assistance R1 required during meals. CNA H stated, R1 was encouragement assistance at the time from what I was aware. The CNA care plan in Matrix and in the binder is where that information is located. Since this incident though the binder has gone away and we are to only use the care plan in Matrix. Surveyor asked CNA H what the fork and knife next to your name on the schedule means. CNA H stated the fork and knife on the schedule means you are responsible for the dining room and to be serving trays. I was not in the dining room though; I had asked CNA I and LPN D to assist in the dining room while I assisted another resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/29/24 at 12:00 PM, Surveyor interviewed CNA I. Surveyor asked CNA I what she remembers from the incident on 10/13/24. CNA I stated, I was passing trays in the dining room. I can't remember who gave R1 her tray. Usually, R1 required supervision. R1 would eat on her own once given a tray. Surveyor asked CNA I if she knew what supervision R1 required. CNA I stated, I am unsure what supervision is required. R1 sits at an assist table for that and her ailments I would assume. Surveyor asked CNA I if she knows how or who serves the trays to residents that require assistance or supervision. CNA I stated, I am not sure how trays are served to the residents at the assist table. Surveyor asked CNA I if she assisted LPN D. CNA I stated, LPN D told me she heard R1 scream which I don't recall hearing. LPN D came into the dining room asking for my help. Surveyor asked CNA I if she saw LPN D come into the dining room to get R1. CNA I stated, I did not see LPN D come get R1 from dining room. When I went to assist LPN D, R1 was covered in soup. We transferred R1 to the bed to get her clothes off so that LPN D could assess her skin. R1's skin was peeling, red, and you could see the burn. The areas did not blister right away but within 10-15 minutes noted blistering. Cold washcloths were applied to the burned areas. Surveyor asked CNA I if she remembered seeing any other staff in the dining room. CNA I stated, I don't remember any other staff in the dining room. Of note: Nursing and CNA staff schedules have knife/fork next to names. Surveyor asked what that meant and was told by staff that those people are responsible for the dining room (serving, assist and supervision). During interviews staff indicate they are not always the ones that go to the dining room if they are busy. On 10/29/24 at 3:35 PM, Surveyor interviewed Director of Nursing (DON) B, Regional Nurse Consultant (RNC) C and Nursing Home Administrator (NHA) A. Surveyor asked what supervision means in relation to residents needing supervision during meals. DON B stated, in the dining room where staff can see her, but they do not have to be sitting with her. Surveyor asked how you ensure residents are safe with their hot liquids and foods, when they have been identified at risk. DON B stated clothing protector on times two and cups with lids. Surveyor asked what happens if a resident will not keep lid on cups. DON B stated, we would encourage them to keep the lid on and ask if we could cool the liquid down. If still refusing to keep lid on would expect staff still sit with them. Surveyor asked what the fork and knife meant on the staffing schedule. DON B stated the staff are to be in the dining room. Surveyor asked DON B if schedule is accurate for this. DON B stated, it is not changed on the schedule if someone else goes in the dining room for someone else that is busy, so the schedule is not accurate, and this happens frequently. On 10/29/24 at 8:50 AM, Surveyor observed R1 being served her meal. Staff set up R1's meal and sat with R1. R1 was served French toast sticks, sausage, and juice in a disposable small cup. R1 was eating her food using her left hand to pick up food. Of note: R1 was not served coffee even though it was a preference on her meal ticket. No cups with lids were observed during breakfast and lunch meal observation. On 10/29/24 at 11:45 AM, Surveyor observed [NAME] K taking food temperatures after the foods were put into the steamtable. The temperatures were as follows: Roast beef - 181 degrees Mixed vegetables - 207 degrees (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pureed meat - 204 degrees Gravy - 202 degrees Ground meat - 180 degrees Mashed potatoes with gravy - 186 degrees On 10/29/24 at 11:58 AM, Surveyor interviewed [NAME] L. Surveyor asked [NAME] L what a safe serving temperature was. [NAME] L stated food was to be served at 180 degrees or below; that is a safe serving temperature. Surveyor asked [NAME] L if he was aware of R1's incident of being burned after spilling soup on herself. [NAME] L stated he was the [NAME] for that evening meal. [NAME] L stated he plated the meal service and nursing staff served the residents. Surveyor asked [NAME] L if any changes were made after the incident or if [NAME] L was educated after the incident. [NAME] L stated he was not educated to make any changes; he talked through the incident with the manager and was told everything was fine. On 10/29/24 at 12:50 PM, Surveyor observed R1 being served her meal. Staff set up R1's meal and left R1 to eat independently with a staff member sitting across the table from R1 assisting R3. R1 was served roast beef, mashed potatoes, mixed vegetables, cream pie, and juice in a disposable small cup. R1 was eating her food using her left hand to scoop the food up and into her mouth. Of note: R1 was not served coffee even though it was a preference on her meal ticket. No cups with lids were observed during meal service. On 10/29/24 at 1:00 PM, Surveyor received a test tray. Test tray temperatures were as follows: Roast beef - 140 degrees, palatable Mashed potatoes with gravy - 160 degrees, very hot to taste, burning Surveyor's tongue Mixed vegetables - 133 degrees, palatable Milk - 55 degrees, palatable On 10/29/24 at 1:10 PM, Surveyor interviewed Dietary Manager (DM) M. Surveyor asked DM M what his credentials were to be a Dietary Manager. DM M stated he was going through the CDM (Certified Dietary Manager) course. DM M stated he has a Corporate Dietician who he can consult with. Surveyor asked DM M when he would expect food temperatures to be taken. DM M stated the cook staff are to take temperatures at the steam table just before meal service begins. DM M stated this is a new policy since R1's incident of spilling soup. Surveyor asked for proof of education for other staff and was not provided the education. On 10/29/24 at 1:20 PM, Surveyor asked [NAME] K when she is to take hot food temperatures. [NAME] K stated she takes hot food temperatures when she removes the food items from the oven. Surveyor asked [NAME] K if she was ever educated to take hot food temperatures from the steam table just prior to meal service. [NAME] K stated no. DM M stated [NAME] K had been on vacation and had not yet been educated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER: Mulder Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 713 Leonard St N West Salem, WI 54669	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked DM M to review the Daily Food Temperature Log for tray line. The log showed the following, in part: 10/13/24 - Dinner: Soup - 178 (degrees) Starch/gravy - 186 (degrees) Vegetable - 189 (degrees) Ground Meat - 182 (degrees) Puree Meat - 177 (degrees) Puree Vegetable - 181 (degrees) Coffee/Tea - 182 (degrees) 10/19/24 -Breakfast: Hot Cereal - 203 (degrees) Entree - 153 (degrees) Sausage/Puree - 203 (degrees) Puree Entree - 173 (degrees) Coffee - 171 (degrees) Surveyor asked DM M if these hot food item temperatures were taken when the foods were removed from the oven or at the steam table prior to service. DM M stated he was not sure. Surveyor asked DM M what safe serving temperatures of food was. DM M stated safe serving temperatures were 180 degrees and below for hot foods. Surveyor asked DM M what, if any, changes were made for residents who receive hot food and liquids and were at risk for spilling. DM M stated residents who are at risk are provided lids on cups and bowls. Surveyor asked DM M if R1 was provided lids on her cups and bowls. DM M stated yes, R1 is provided lids on her cups and bowls. DM M stated he does beverage pass before breakfast on days he is working. DM M stated he provides R1 with hot coffee in a covered cup. DM M stated R1 will remove the lid and drink the coffee. DM M stated he tells R1 she should leave the lid on the cup, but R1 still removes the lid. DM M stated he does not stay with R1 when she is drinking her coffee; there are staff in the dining room, and they keep an eye on her. The facility's failure to provide adequate supervision and assistance during meals and the failure to ensure foods and fluids were served at a temperature that would not cause burns created a reasonable liklelihood fore serious injury thus leading to a finding of immediate jeopardy. The facility removed the immediacy on 10/30/24 when they implemented the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Mulder Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 713 Leonard St N West Salem, WI 54669	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- All residents have been assessed and care plans have been updated to the level of supervision during meals (1:1, direct, or indirect). - Temperatures have been taken in the kitchen every 15 minutes on the serving steam table tray line due to a need for a part replacement. Part replacement occurred 11/1/24 prior to service. - Test trays are done at the point of service for all residents in the dining room and one on each hall tray carts to be checked prior to beginning of service to verify food temp is 135-150 degrees. - Residents that have a risk of hot liquid injury have cups with lids that snap on and are more difficult to remove and also have staff supervision per their care plan approach as agreed upon by IDT and therapy. - Starting 10/30/24, dietary staff have had direct supervision at meals and assist taking temperatures of foods prior to service. - Dietary staff is being educated on the correct temperatures of service of food to be between 135-150 degrees at the point of service to the residents. - Policies have been changed to reflect this change. - Nursing staff is being educated on the definition of supervision that is expected in the dining room with the residents that require supervision. This is being audited at every meal to monitor compliance with every meal that residents at risk are having the correct level of supervision that is required to maintain safety with hot liquids/foods. - Maintenance checked the steam table and parts were ordered and expedited. Replaced on 11/1/24 prior to the start of service. - Facility will continue with weekly checks of the steam table for proper function. Due to faulty parts the temps on the food in the steam table were checked every 15 minutes to maintain safe temps. - QAPI meeting held related to PIP started in relation to the changes that need to be completed. This was held on 10/30/24 at 1700. - Staff education started with temperature changes in the dietary dept started at 1700 on 10/30/24. - Education to nursing staff related to the definition of supervision: 1:1, direct, and direct, started on 10/30/24 at 1700. - Care plans related to the level of supervision that is required for residents at risk with hot liquids updated and educated to nursing staff starting at 1700 on 10/30/24. - All education is ongoing with this being completed prior to the start of the next working shift. - Both tray audits and the supervision audits are being completed at all 3 meals 7 days per week to maintain the safe environment for the residents at meal time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulder Health Care Facility	713 Leonard St N West Salem, WI 54669

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 10/31/24, resident council meeting held for the update of the residents to the recent changes and the updates to dining service. - At this time all staff that have worked in the facility have been educated to the changes in policy and the level of supervision that is to be provided in the dining room at all meals.