STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525209	A. Building B. Wing	12/16/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39713 Based on record review and interview, the facility did not immediately consult with the resident's physician when 1 of 3 sampled residents (R1) experienced a significant change or required a change in treatment. R1's physician was not consulted when R1's oxygen saturation and pulse fell below the desired range. This is evidenced by the following: The facility policy and procedure Notification of Change, last reviewed 1/24, states, in part: Introduction: The Residents physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change of condition, potential discharge, room transfer for death. Notification Parameters: [Facility] has adopted the current INTERACT Tools Change of Condition: When to report to the MD (Medical Doctor)/NP (Nurse Practitioner)/PA (Physician Assistant). ** The INTERACT program is an evidence-based program that may be utilized by the nurse when needed and does not supersede the clinical judgement of the licensed nurse. A Physicians personal request for notification of a condition may supersede the INTERACT Recommendations. Some Physicians may require different notification parameters for conditions such as blood glucose or other conditions. Please follow the Physicians order in these cases. NOTIFY THE PHYSICIAN IMMEDIATELY IF THE RESIDENT REQUIRES IMMEDIATE ACTION Notification: 1. Call the physician and document using the SBAR Communication Form and/or Progress Note. 2. In the nurses judgement if the situation requires immediate notification but is not an immediate emergency and the physician has not responded the will [sic] continue to assess the residents condition and document. If a return call is not received a second call may be placed. If there is no response to a second call the Medical Director may be notified for guidance. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/23/24 at 9:36 AM, Nurses Progress Note, states, Writer arrived at 620 (6:20 AM) and was immediately informed by LPN D (Licensed Practical Nurse) that resident was unresponsive and without a pulse. Writer immediately responded to resident room and assessed resident. Resident was lying in bed peacefully. No respirations were noted. Her skin was warm, and she did not appear to be in distress. Heart sounds auscultated and no sounds were observed for 2 minutes. LPN D auscultated and was unable to hear heart sounds. POST (Provider Order for Scope of Treatment) was at bedside and confirmed that resident desired DNR (Do Not Resuscitate) per form. She had been O [sic]-DNR/DNI (Do Not Resuscitate/Do Not Intubate) as designated by POST and discharge orders. LPN D began end of life notifications/process. R1's vitals from 11/22/24 and 11/23/24 are documented in part as . 11/22/24 at 4:50 PM: O2 Saturation 70%, Pulse 46/per minute 11/22/24 at 9:33 PM: O2 Saturation 99% on 2 L/min (liters per minute), Pulse, no pulse obtained 11/22/24 at 10:32 PM: Pulse 56/per minute 11/22/24 at 10:34 PM: Pulse, 46/per minute 11/22/24 at 10:43 PM: O2 Saturation 96% on 2L/min, Pulse 56/per minute 11/23/24 at 1:16 AM: O2 Saturation 98% on 2L/min, Pulse, no pulse obtained 11/23/24 at 5:01 AM: O2 Saturation 95% on 2L/min, Pulse, no pulse obtained R1's MAR (medication administration record) states in part . Order: Covid Monitoring: Monitor resident for shortness of breath, lung sounds, respirations, O2 saturations and temperature every 4 hours x (times) 72 hours. 11/22/24 at 8:00 PM: Temperature: 98.7, Respirations 16, O2 Saturation 99%, Lung sounds clear, SOB (shortness of breath) present (yes/no): Y (Yes). 11/23/24 at 12:00 AM: Temperature: 97.7, Respirations 15, O2 Saturation 98%, Lung sounds clear, SOB (shortness of breath) present (yes/no): Y (Yes). 11/23/24 at 4:00 AM: Temperature: 97.7, Respirations 16, O2 Saturation 95%, Lung sounds clear, SOB (shortness of breath) present (yes/no): Y (Yes). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 12:03 PM, Surveyor interviewed MDS J (Minimum Data Set Nurse). MDS J is a Registered Nurse. Surveyor asked MDS J about her interaction with R1. MDS J stated she went to R1's room to complete the malnutrition screening. MDS J stated she knocked on R1's room door and stated she had some questions for R1. MDS J stated she was standing in R1's doorway. R1 was sitting on the side of the bed with the tray table in front of R1. MDS J asked R1 how are you today, I am here to do a malnutrition screen if R1 has time. R1 stated to MDS J I think I am having a hard time breathing. MDS J stated R1 did not look like she was in distress. MDS J stated she asked R1 if she was ok, R1 stated yes, I am ok. MDS J stated that she would go get R1's nurse. MDS J stated all she had with her was a piece of paper and a pen. MDS J stated if R1 was having distress she would have gone into R1's room. MDS J stated to R1 I will be right back; I will go get your nurse. MDS J stated she was not sure if she left R1's room door open or closed. MDS J stated she knew R1's nurse was at the nurse's station. MDS J walked down the hallway and reported to LPN E R1's complaint of difficulty breathing. MDS J stated LPN E stated she was going to get DON B and walked away. On 12/16/24 at 12:19 PM, Surveyor interviewed LPN E (Licensed Practical Nurse). Surveyor asked LPN E about R1's admission. LPN E stated R1 was admitted between 3:00 PM - 4:00 PM. LPN E stated DON B (Director of Nursing) also assisted with the admission assessment. LPN E stated it was difficult to get R1's oxygen saturation level. R1's oxygen saturation was found to be 93%. LPN E stated R1 was not using any supplemental oxygen at the time of admission. LPN E stated she was sitting at the desk charting when MDS J (Minimum Data Set Nurse) came up to her and stated that R1 was complaining of shortness of breath and complained of having a hard time breathing. LPN E stated she went to DON B and informed DON B that R1 was complaining of shortness of breath and having a hard time breathing. LPN E and DON B went to R1's room. LPN E went into R1's room while DON B and MDS J were outside R1's room. LPN E attempted to get R1's oxygen saturation. LPN E stated she had a difficult time getting R1's oxygen saturation, LPN E asked R1 to sit up straight, R1's oxygen saturation was 71% and continued to be between 71% - 76% at 4:50 PM. LPN E stated she asked staff to bring R1 some oxygen. R1's oxygen saturation went up to 90% after receiving oxygen. LPN stated at that time R1 stated she felt more comfortable. LPN E stated R1's lung sounds were checked, and the only thing noticed was R1's oxygen saturation was positional. When R1 sat up straight, her oxygen saturation would go up. Surveyor asked LPN E if she had contacted R1's physician when R1's oxygen went down to 71%. LPN E stated she was told that DON B updated R1's physician. On 12/16/24 at 12:44 PM, Surveyor interviewed RCD C (Regional Clinical Director). Surveyor asked RCD C if anyone had called R1's physician when she complained of difficulty breathing and had an oxygen saturation of 71%. RCD C stated it did not appear so. Surveyor asked RCD C if a physician should be notified when a resident's oxygen saturation is 71%. RCD C stated yes. Surveyor asked RCD C if a physician should be notified when a resident has difficulty breathing. RCD C stated yes, a physician should be notified. RCD C stated there was no documentation in R1's medical record that a physician was contacted. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 1:30 PM, Surveyor interviewed RCD (Regional Clinical Director). Surveyor asked RCD C where Surveyor should find documentation of R1's physician being notified of her change of condition. RCD C stated, I will see if DON B sent an email to the provider about the change of condition. Surveyor asked RCD C if that information should be found in R1's medical record. RCD C stated, yes, if it is not documented it is not done. On 12/16/24 at 1:40 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A where Surveyor would be able to find information showing a physician was notified of a change of condition. NHA A stated, that should be done and charted in the medical record. If it was not charted then it is considered not done. DON B states that she did notify the provider via email on R1's change of condition. DON B should have documented this in R1's chart. Surveyor asked NHA A if a phone was needed or if an email regarding R1's change of condition was sufficient. NHA A stated, this change of condition needed to be done by a phone call not an email. On 12/16/24 at 2:11 PM, Surveyor interviewed LPN D. Surveyor asked LPN D to talk about R1's stay at the facility. LPN D stated, I knew that R1 was a new admission, but she had been her on a prior stay. I completed tasks on R1 at midnight and 4:00 AM. I knew she was not in great shape. I found her unresponsive after 6:00 AM and I had last seen her at 4:00 AM when I completed the tasks. When I found R1 unresponsive I went and got the Supervisor, LPN K. As I was talking with LPN K, DON B came in and that was about 6:20 AM - 6:30 AM. Tasks that I completed at midnight and 4:00 AM were O2 and communication. Surveyor asked LPN D if he completed lung assessments/listened to lung sounds during the midnight and 4:00 AM tasks. LPN D stated, I didn't do any lung sounds until I found her unresponsive. Surveyor then asked LPN D about charting that indicates that R1's lungs were clean at midnight and 4:00 AM. LPN D stated, if I charted lungs were clear then I must have listened but can't be sure. At the end of the shift when R1 was found unresponsive I did a more extensive assessment. On 12/16/24 at 3:00 PM, Surveyor interviewed NP F (Nurse Practitioner). Surveyor asked NP F if she was notified of R1's change of condition. NP F stated, I was notified via email on the evening of 11/22/24 but I didn't respond to that email until 11/24/24. Surveyor asked NP F if a call should have been made to update her or the physician of R1's change of condition. NP F stated, the on-call physician should have been notified but I am not aware they were contacted either. On 12/16/24 at 3:15 PM, Surveyor interviewed RN G. Surveyor asked RN G process for finding a resident with low O2 saturation. RN G stated, probably start oxygen, completed a respiratory assessment, and notify the physician. We use INTERACT tool for our SOP (standard of practice) for notification of change of condition. On 12/16/24 at 3:25 PM, Surveyor interviewed LPN H. Surveyor asked LPN H what facility process is for change of condition. LPN H stated, notify the physician, document findings and physician orders, and notify the supervisor. On 12/16/24 at 3:30 PM, Surveyor interviewed LPN I. Surveyor asked LPN I what facility process is for change of condition. LPN I stated, take a full set of vital signs, call physician and notified of change of condition. Document the findings and any new orders and notify the supervisor or on-call nurse. (continued on next page)

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