

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 09/16/2025
NAME OF PROVIDER OR SUPPLIER Mulder Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility did not ensure each resident remained free from abuse for 1 of 8 sampled residents (R4).R4 was spoken to in a manner that is described by the resident as abusive; the resident also states that staff did not release her wrist as requested.The facility policy, titled Abuse Prevention Program, dated last reviewed 01/2025, states, Each resident has the right to be free from abuse, neglect and corporal punishment of any type by staff or anyone. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.R4 was admitted to the facility in 2024, with diagnoses including, gastroenteritis, rheumatoid arthritis, osteoarthritis, weakness, and anxiety disorder. R4 is alert and oriented and able to make her needs known.Surveyor interviewed R4 on 09/16/25 at 10:30 AM. When asked if she had had any recent care concerns, R4 responded that the other night a Certified Nursing Assistant (CNA), CNA G, had been haughty, condescending, and dictatorial, insisting that she move her pencil box off her bed herself. R4 stated CNA G pushed the over the bed table closer to her and insisted R4 pick it up, or she would leave. R4 stated CNA G grabbed her wrist twice. R4 stated the other gal, CNA D, called for the nurse, and the nurse came in and made CNA G leave. R4 stated CNA G had grabbed her right wrist, trying to force her to roll over. R4 stated that she told CNA G to let go but she didn't. R4 stated CNA G was yelling in her face. Surveyor asked how close CNA G was when she was in R4's face. R4 held her hand up to show the distance. Surveyor clarified, About a foot and a half away? R4 responded Yes. R4 stated CNA G was condescending, ordering her around like a 3-year-old. Other CNAs are polite. R4 stated she asked her to leave 3-4 times, but she didn't. When Surveyor asked if R4 was afraid, R4 responded, a little bit, her attitude, was more and more escalating. When asked if she had pain from being grabbed, R4 responded, it left no marks, but CNA G held it tightly. When asked if it made her cry, R4 said no. When asked if she feels CNA G was abusive to her, she stated, Yes. When asked if she was still afraid R4 stated, No, she hasn't been back. When asked if she feels safe, R4 stated, Yes, and added that overall, her care has been good. During the interview, R4 remained calm when speaking about the incident, the pace of her language did not change and she showed no changes in facial expression. Surveyor interviewed CNA D on 09/16/25 at 8:21 AM. CNA D worked with R4 on 09/09/25 at approximately 10:45 PM when the incident occurred. CNA D stated she asked CNA G to come assist her with R4's cares, as R4 requires the assistance of 2 staff, due to making false allegations towards staff. CNA D stated that when she first approached CNA G to ask for assistance with R4's cares, CNA G immediately said, No. CNA D stated she then explained no other staff were able to come assist, so CNA G came. CNA D stated that CNA G spoke to R4 in a condescending manner. CNA D stated that CNA G grabbed R4's wrist and did not let go when the resident asked. CNA D stated CNA G was scolding R4 and described the situation as a power trip.Review of CNA D's statement dated 09/09/25 at 10:45 PM reveals the following information. CNA D's statement states that CNA G told R4 she needed to move her belongings. R4 stated to move it for her. CNA G then responded, I'm not moving your belongings, you can, otherwise we can't help you. R4 then told staff, That's fine you can leave. CNA D then stated that if she leaves, I can't help you; there's no other staff that feels comfortable to help you on tonight. R4 asked who else could from other halls. CNA D stated she told her who, then CNA G stated, Do you want me to help?? and the resident said, That's fine. Staff pulled the covers down, and CNA G grabbed the resident's arm/wrist to turn her to her left side. R4 tried to pull her arm away and said, You don't have to grab my arm. CNA G said, I'm trying to put you on the bed pan. Do you want my help or not? CNA G continued to hold onto R4's arm to turn her to assist with putting resident on bed pan. R4 continued to resist. CNA D stated I went to grab the nurse because the situation was not deescalating.On 09/16/25 at 10:30 AM, Surveyor interviewed Licensed Practical Nurse (LPN) F, who stated she was in the hall when she was called to R4's room. LPN F stated that when she entered the room R4's eyes were watering, and she was visibly trembling. LPN F stated CNA G was speaking aggressively and was not appropriate. LPN F stated she asked CNA G to leave a couple of times before she did. LPN F stated that CNA G got really close to R4's face and asked her if she wanted her to leave, and R4 responded that, Yes she wanted her to leave. CNA G responded fine, and then left. When asked if she noticed anything with R4's wrist, LPN F stated the arm was slightly red, near the wrist. When asked if R4 was upset, while she continued with the cares, LPN F stated that R4 calmed as soon as CNA G left the room. When asked if she felt CNA G was abusive to R4, LPN G responded, Yes. LPN F stated she called the Director of Nursing (DON) right away to report the incident and began to gather statements for an</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility did not ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 1 resident incidents reviewed. (R4)R4 was spoken to in a manner that is described by the resident as abusive; the resident also stated that staff did not release her wrist as requested. This was not reported to the state survey agency within 24 hours. This is evidenced by: The facility policy, titled Abuse Prevention Program, dated last reviewed 01/2025, states in part: Reporting/Response All alleged or suspected violations are to be reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including to the State Survey Agency. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R4 was admitted to the facility in 2023, with diagnoses including, gastroenteritis, rheumatoid arthritis, osteoarthritis, weakness, and anxiety disorder. R4 is alert and oriented and able to make her needs known. R4's Minimum Data Set (MDS) assessment, dated 06/29/25, indicated that her brief interview for mental status (BIMS) score is 15/15, indicating intact cognitive function. Surveyor interviewed R4 on 09/16/25 at 10:30 AM. When asked if she had had any recent care concerns, R4 responded that the other night a Certified Nursing Assistant (CNA), CNA G, had been haughty, condescending, and dictatorial, insisting that she move her pencil box off her bed herself. R4 stated CNA G pushed the over the bed table closer to her and insisted R4 pick it up, or she would leave. R4 stated CNA G grabbed her wrist twice. R4 stated the other gal, CNA D, called for the nurse, and the nurse came in and made CNA G leave. R4 stated CNA G had grabbed her right wrist, trying to force her to roll over. R4 stated that she told the CNA to let go, but she didn't. R4 stated CNA G was yelling in her face, to roll over. Surveyor asked how close CNA G was when she was in her face. R4 held her hand up to show the distance. Surveyor clarified, About a foot and a half away? R4 responded, Yes. R4 stated CNA G was condescending, ordering her around like a 3-year-old. Other CNAs are polite. R4 stated she asked CNA G to leave 3-4 times, but she didn't. When asked if she was afraid, R4 responded, a little bit, her attitude was more and more escalating. When asked if she had pain from being grabbed, R4 responded it left no marks, but CNA G held it tightly. When asked if it made her cry, R4 said no. When asked if she feels CNA G was abusive to her, R4 stated, Yes. When asked if she was still afraid, R4 stated, No, she hasn't been back. When asked if she feels safe, R4 stated, Yes, and added that overall, her care has been good. During the interview, R4 remained calm when speaking about the incident, the pace of her language did not change and she showed no changes in facial expression. Surveyor interviewed CNA D on 09/16/25 at 8:20 AM. CNA D worked with R4 on 09/09/25 at approximately 10:45 PM when the incident occurred. CNA D stated she asked CNA G to come assist her with R4's cares, as R4 requires the assistance of 2 staff, due to making false allegations towards staff. CNA D stated that when she first approached CNA G to ask for assistance with R4's cares, CNA G immediately said, No. CNA D stated she then explained no other staff were able to come assist, so CNA G came. CNA D stated that CNA G spoke to R4 in a condescending manner. CNA D stated that CNA G grabbed R4's wrist and did not let go when the resident asked. CNA D stated CNA G was scolding R4 and described the situation as a power trip. Review of CNA D's witness statement dated 09/09/25 at 10:45 PM reveals the following information. CNA D's statement states that CNA G told R4 she needed to move her belongings. R4 stated to move it for her. CNA G then responded, I'm not moving your belongings, you can, otherwise we can't help you. R4 then told staff, That's fine you can leave. CNA D then stated that if she leaves, I can't help you; there's no other staff that feels comfortable to help you on tonight. R4 asked who else could from other halls. CNA D stated she told her who, then CNA G stated, Do you want me to help? and the resident said, That's fine. Staff pulled the covers down, and CNA G grabbed the resident's arm/wrist to turn her to her left side. Resident tried to pull her arm away and said, You don't have to grab my arm. CNA G said, I'm trying to</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to put measures in place to prevent further abuse, following an allegation of abuse, for 1 of 1 allegation reviewed. This has the potential to affect a pattern of the facility's 75 residents. On 09/09/25, allegations of potential abuse were reported against Certified Nursing Assistant (CNA) G. CNA G was allowed to continue working with residents for the rest of that shift and worked again on 09/11/25 and 09/12/25 during the facility's investigation. This is evidenced by: The facility policy, titled Abuse Prevention Program, dated last reviewed 01/2025, states in part: Upon recognizing signs/symptoms of stressed staff, the observer will take action which may include but is not limited to. relieve the staff member of direct care duties. The investigation must include but not limited to: Identify alleged perpetrator, remove from resident care area immediately, suspend pending investigation conclusion, obtain statement. R4 was admitted to the facility in 2023, with diagnoses including, gastroenteritis, rheumatoid arthritis, osteoarthritis, weakness, and anxiety disorder. R4 is alert oriented and able to make her needs known. R4's Minimum Data Set (MDS) assessment, dated 06/29/25, indicated that her brief interview for mental status (BIMS) score is 15/15, indicating intact cognitive function. Surveyor interviewed R4 on 09/16/25 at 10:30 AM. When asked if she had had any recent care concerns, R4 responded that the other night a CNA, CNA G, had been haughty, condescending, and dictatorial, insisting that she move her pencil box off her bed herself. R4 stated CNA G pushed the over the bed table closer to her and insisted R4 pick it up, or she would leave. R4 stated CNA G grabbed her wrist twice. R4 stated the other gal, CNA D, called for the nurse, and the nurse came in and made CNA G leave. R4 stated CNA G had grabbed her right wrist, trying to force her to roll over. R4 stated that she told the CNA to let go, but she didn't. R4 stated CNA G was yelling in her face, to roll over. Surveyor asked how close CNA G was when she was in her face. R4 held her hand up to show the distance. Surveyor clarified, About a foot and a half away? R4 responded, Yes. R4 stated CNA G was condescending, ordering her around like a 3-year-old. Other CNAs are polite. R4 stated she asked CNA G to leave 3-4 times, but she didn't. When asked if she was afraid, R4 responded, a little bit her attitude, was more and more escalating. When asked if she had pain from being grabbed, R4 responded it left no marks, but CNA G held it tightly. When asked if it made her cry, R4 said no. When asked if she feels CNA G was abusive to her, she stated, Yes. When asked if she was still afraid, R4 stated, No, she hasn't been back. When asked if she feels safe, R4 stated, Yes, and added that overall, her care has been good. During the interview, R4 remained calm when speaking about the incident, the pace of her language did not change and she showed no changes in facial expression. Surveyor interviewed CNA D on 09/16/25 at 8:20 AM. CNA D worked with R4 on 09/09/25 at approximately 10:45 PM when the incident occurred. CNA D stated she asked CNA G to come assist her with R4's cares, as R4 requires the assistance of two staff, due to making false allegations towards staff. CNA D stated that when she first approached CNA G to ask for assistance with R4's cares, CNA G immediately said, No. CNA D stated she then explained no other staff were able to come assist, so CNA G came. CNA D stated that CNA G spoke to R4 in a condescending manner. CNA D stated that CNA G grabbed R4's wrist and did not let go when the resident asked. 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CNA G continued to hold onto R4's arm to turn her to assist with putting resident on bed pan. R4 continued to resist. CNA D stated I went to grab the nurse because the situation was not deescalating. On 09/16/25 at 10:30 AM, Surveyor interviewed Licensed Practical Nurse (LPN) F who stated she was in the hall when she was called to R4's room. LPN F stated that when she entered the room R4's eyes were watering, and she was visibly trembling. LPN F stated CNA G was speaking aggressively and was not appropriate. LPN F stated she asked CNA G to leave a couple of times before she did. LPN F stated that CNA G got really close to R4's face and asked her if she wanted her to leave, and R4 responded that Yes she wanted her to leave</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, 1 of 8 sampled residents (R1) was not provided with supervision to prevent accidents.R1 was being transferred to the bathroom via EZ stand when her shoulder was bumped into the door frame; the CNA staff who were assisting the resident at the time did not report this incident to the charge nurse.This is evidenced by: The facility policy, titled Resident Incident/Accident Reporting Protocol, dated reviewed 01/2025, states, All incidents and accidents (regardless of how minor they may present) must be reported to the Charge Nurse immediately upon discovery with a completed applicable event report and communicated to the oncoming shift.R1 was admitted to the facility with diagnoses including, right sided hemiplegia, impaired mobility, hypertensive intracerebral hemorrhage, chronic pain, and osteoarthritis.Surveyor reviewed a witness statement written by Registered Nurse (RN) C on 08/23/25, which states in part: During AM medication pass, resident was complaining of 10/10 pain in right arm. Resident stated last night (8/22) . was being transferred by EZ stand to bathroom, arm was hit on the door frame on accident. R1 indicated the Certified Nursing Assistant (CNA) stated sorry after.After this incident was reported by the resident on 08/23/25, the facility gathered other statements including the ones below. Surveyor reviewed a witness statement written by CNA D on 08/23/25, which states in part: I assisted with putting resident on toilet, her right arm was brushed against the door due to easy stand barely fits and resident arm was hanging, Resident stated it hurt but it was fine. It occurred on 08/22/25, at approximately 9:15 PM.Surveyor reviewed a witness statement written by CNA E which states in part was using EZ stand with resident to use the bathroom and while pushing her in to the bathroom her right arm hit the frame of the door. I apologized and repeatedly asked if she wanted an ice pack, and she said no. It occurred on 08/22/25, at approximately 9:30 PM.Surveyor reviewed R1's medical record and could not locate any information related to the above incident in the medical record on 08/22/25, when the incident occurred.Interview with DON B on 09/15/25 at 3:40 PM confirmed that CNAs did not report the incident to the nurse working with R1 at the time of the incident, or the charge nurse, or to the oncoming shift, as the policy directs.</p>		