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	01/22/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interviews, the facility failed to ensure four Residents (R)2, R3, R4 and R5) of a total of 16 residents reviewed for abuse/neglect/misappropriation were free from misappropriation of funds when money was stolen from each of the residents by a staff member (Certified Nursing Assistant (CNA1)). The facility's failure to ensure residents were free from misappropriation of property/funds created the potential for these and other residents to experience psychosocial harm related to the misappropriation and/or continued misappropriation of property/funds. A total of 16 residents were reviewed in the sample. Findings include:1. Review of R2's Resident Face Sheet, dated 01/22/26 and found in the EMR under the CCD Tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Adult Failure to Thrive and heart disease. The resident was discharged from the facility on 12/17/25. Review of R2's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/05/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact.Review of R2's record, including the Progress Notes, dated 08/01/25 through 12/17/25 and found in the EMR under the Progress Notes Tab, revealed nothing related to R2's allegation of misappropriation of property by CNA1. Review of the facility's investigation into R2's allegation of misappropriation, dated 10/03/25, revealed R2 reported she woke up from sleeping in her bed and CNA1 was in her room taking money from her wallet. A thorough investigation into the resident's allegation was completed by the facility. Additional reports of potential misappropriation of funds by CNA1 were received during the investigation. The facility report indicated, While the facility cannot definitively prove [CNA1 stole any money, the investigation led to questions regarding her involvement with multiple instances of missing money raises too many concerns, and the decision to terminate [CNA1's] employment has been made. [CNA1's] employment with the facility was terminated as a result of the investigation. R2 was not able to be interviewed related to the allegation of misappropriation of property since she was no longer residing in the facility.2. Review of R3's Resident Face Sheet, dated 01/22/26 and found in the EMR under the CCD Tab, revealed the resident was admitted to the facility on [DATE]. R3's diagnoses included morbid obesity and heart disease. Review of R3's Quarterly MDS assessment, with an ARD of 11/03/25 and found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R3's record, including the Progress Notes, dated 07/31/25 through 01/22/26 and found in the EMR under the Progress Notes Tab, revealed nothing related to R3's allegation of misappropriation of property by CNA1. Review of the facility's investigation into R3's allegation of misappropriation, dated 10/03/25, revealed during the facility's investigation related to R2's allegation of stolen money, R3 was interviewed and stated two to three weeks after her admission to the facility $55 to $75 dollars was taken out of her wallet. A thorough investigation was completed by the facility related to R3's report of missing (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	money. Additional reports of potential misappropriation of funds by CNA1 were received during the investigation of missing funds for R2 and R3. The facility report indicated CNA1's employment with the facility was terminated as a result of the investigation. R3 was interviewed on 01/20/26 at 1:38 PM and confirmed money had been stolen from her during her first two to three weeks at the facility. 3. Review of R4's Resident Face Sheet, dated 01/22/26 and found in the EMR under the CCD Tab, revealed the resident was admitted to the facility on [DATE]. R4's diagnoses included congestive heart failure chronic kidney disease. Review of R4's Quarterly MDS assessment, with an ARD of 11/11/25 and found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated R4 was cognitively intact.Review of R4's record, including the Progress Notes, dated 05/01/25 through 01/22/26 and found in the EMR under the Progress Notes Tab, revealed nothing related to R4's allegation of misappropriation of property by CNA1. Review of the facility's investigation into R4's allegation of misappropriation, dated 10/03/25, revealed during the facility's investigation related to R2's initial allegation of stolen money, R4 was interviewed and stated $50 to $65 dollars was stolen from her in May of 2025. A thorough investigation was completed by the facility related to R4's report of missing money. Additional reports of potential misappropriation of funds by CNA1 were received during the investigation of missing funds. The facility report indicated CNA1's employment with the facility was terminated as a result of the investigation. During an interview on 01/20/26 at 1:50 PM R4 stated, That lady [CNA1] stole my money. I don't remember exactly when. They [the facility] fired her. She has not been back.4. Review of R5's Resident Face Sheet, dated 01/22/26 and found in the EMR under the CCD Tab, revealed the resident was admitted to the facility on [DATE]. R5's diagnoses included history of stroke. Review of R5's Quarterly MDS assessment, with an ARD of 12/11/25 and found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R5's record, including the Progress Notes, dated 12/04/24 through 01/22/26 and found in the EMR under the Progress Notes Tab, revealed nothing related to R5's allegation of misappropriation of property by CNA1. Review of the facility's investigation into R5's allegation of misappropriation, dated 10/03/25, revealed during the facility's investigation related to R2's initial allegation of stolen money, R5 she had money go missing a while ago but she did not remember exactly when. The investigation indicated R5 named CNA1 as the person who she thought took her money. A thorough investigation was completed by the facility related to R5's report of missing money. Additional reports of potential misappropriation of funds by CNA1 were received during the investigation of missing funds. The facility report indicated CNA1's employment with the facility was terminated as a result of the investigation. During an interview with R5 01/20/26 at 1:30 PM, she stated, That money was taken almost a year ago. They [the facility] handled it. She [CNA1] was let go. I haven't seen her since.During an interview with the Director of Nursing (DON) and the Administrator on 01/22/25 at 12:33 PM, the Administrator confirmed the allegations of misappropriation of funds by CNA1. The Administrator stated the facility's investigation into the allegations of misappropriation of R2, R3, R4 and R5's money revealed CNA1 likely stole the residents' money and CNA1 was terminated and reported to the local Police Department as a result of the investigation. The Administrator stated his expectation was residents residing in the facility would be free from all forms of abuse including misappropriation of property. Review of the facility's Abuse Prevention Program Policy and Procedure dated last revised/reviewed in 01/2025 indicated, Each resident has the right to be free from abuse, neglect and corporal punishment of any type by staff or anyone. The facility will provide a safe environment and protect residents from abuse; and Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of residents' belongings (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or money without the resident's consent; and The provision of training on abuse prohibition alone does not relieve the facility of its responsibility to assure that the resident is free from abuse. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review and interviews, the facility failed to ensure consistent and comprehensive management of nutritional services for one Resident (R) R14) out of three residents reviewed for nutrition. The facility's failure to ensure consistent nutritional interventions were provided for R67 created the potential for this and other residents to experience significant/unanticipated weight loss or nutritional deficits. A total of 50 residents were reviewed in the sample. Findings include:Review of R14's Resident Face Sheet, dated 01/22/25 and found in the EMR under the Continuity of Care Document (CCD) Tab, revealed the resident was admitted to the facility on [DATE], with diagnoses included dementia, chronic and acute kidney disease and cellulitis of her left lower limb. Review of R14's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/12/26 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of one out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated no significant weight loss prior to admission to the facility.Review of R14's dietary physician's orders, dated 01/15/26, and found in the EMR under the Orders Tab, revealed an order for the resident to receive a regular chopped diet with thin liquids. The orders indicated R14 was to be weighed weekly on shower days (Sundays) and R14 was to be offered a bedtime snack each evening and was to receive ProStat (a protein liquid) 30 milliliters (MLs) twice daily to support wound healing. Review of R14's care plan, revised 01/16/26, and found in the EMR under the Care Planning Tab, revealed the resident was at risk for significant weight loss. The care plan indicated all foods were to be served a regular diet cut into bite sized pieces, R14's intake was to be monitored and was to receive diet as ordered.Review of R14's current diet card/tray card, issued with R14's meal on 01/21/26 and used by dietary and nursing staff to ensure R14 was receiving her appropriate diet, revealed R14 had no recorded disliked food or fluid and revealed R14 was to receive a soft and bite sized regular diet. Review of R14's Weight Record, dated 01/21/26 and found in the EMR under the Vital Signs Tab, revealed the following weights:01/06/26: 118 pounds01/07/26: 113.8 pounds01/08/26: 114.0 pounds01/11/26: 110.0 poundsThere was no recorded weight entered into the record after 01/11/26. Review of R14's Vitals Report, dated 01/06/26 through 01/21/26 and provided directly to the survey team, revealed R14's meal intake was not recorded consistently per her plan of care. The record indicated meal intake was not recorded for 10 of a total of 46 meals consumed by R14 since admission to the facility on [DATE]. Review of R14's Initial Nutritional Assessment, dated 01/06/26 and found in the EMR under the Observations Tab, revealed R14 was at risk for significant weight loss. The document indicated R14 was underweight and indicated Will monitor need for additional high calorie supplements pending intake adequacy, skin, weight trends. RD (Registered Dietician) to update plan of care as needed.Review of R14's record revealed nothing to indicate the facility follow-up related to R14's weight loss since admission or effort made to document meal intake accurately or obtain weights according to her physician's orders. On 01/21/26 at 4:00 PM, R14 was observed as facility staff obtained R14's weight, which was 114.4 pounds. During an interview with the Director of Nursing (DON) and the Administrator on 01/22/25 at 12:33 PM, the DON confirmed the facility was not able to locate any documentation to show R14 had been weighed after 01/11/26 and had not been able to find anything to indicate the resident's meal intake had been documented consistently in her record. The DON stated her expectation was residents were to be weighed as ordered by the physician and meal intake was expected to be documented for each meal so the team would be able to determine and address any concerns with nutritional intake patterns. The DON confirmed facility staff should have been monitoring R14 more closely related to her nutritional status due (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to her medical status and recorded loss of weight while in the facility. Review of the facility's Weight and Height Records Policy dated last revised/reviewed in 01/2025 indicated, Residents will have their weight obtained by certified and licensed staff at monthly intervals unless more frequent monitoring is needed as determined by resident weight record, medical condition, or clinical staff; and Weight orders will be placed in the EMR if more frequent monitoring is needed than stated in facility policy; and Weights will be recorded in the EMR when obtained.Review of the facility's Monitoring Nutrient Intake Policy dated last revised/reviewed 01/2025 indicated, Nursing services will record intake according to percentage of entire meal eaten; and Nursing will document percentage of consumption of each meal and substitution in resident's record.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to ensure menus were followed. This failure placed 78 of the 79 residents in the facility at risk for nutritional problems and dissatisfaction with their meals. Findings include:1. A review of the week three menu provided to the survey team indicated that on 01/20/26 the dinner meal would be Minestrone Soup, Saltines, Grilled Cheese sandwich, Lettuce, Tomato, Onion, French Fries, Apple Slices, Ketchup, Margarine, 2% (percent) milk and/or coffee. However, during the meal observation at 5:15 PM, residents were served a dinner consisting of Minestrone soup, a grilled cheese sandwich, canned pears, and a choice of 2% milk, coffee, or juice. There was no observation of French fries, apple slices, lettuce, tomato and onions as documented on the menu, A review of the week three menu for lunch on 01/21/26 would include Chili with Beans, Baked Potato, Sweet Potato Cornbread, Red Grapes, Sour Cream and Chives, Margarine, and 2% milk, coffee, or tea. An observation made at 12:30 PM, the residents received Chili with Beans, Baby Baked Potatoes, Sweet Potato Cornbread or Dinner Roll, Red Grapes, and the choice of 2% milk, coffee, or juice. There was no observation of sour cream and chives as documented on the menu. A review of the week three menu for supper on 01/21/26 would include Corn Dogs, Creamy [NAME] Slaw, Banana, Margarine, 2% milk, coffee, or tea. An observation made at 5:15 PM, the residents received Corn Dogs, Tater Tots, Coleslaw, Sugar Cookies, and a choice of 2% milk, coffee and/or juice. There was no observation of tater tots or a banana as documented on the menu. During an interview on 01/21/26 at 2:01 PM, Cook1 stated, The menus are pre-made, and we are on a four-week rotation. We usually don't order potatoes to bake because they come in so big that we are wasting more than what the residents are eating. That is why we went to the baby baker potatoes. We usually don't include the sour cream and chives because we can't split them like we did with the baked potatoes.During an interview on 01/22/25 at 12:33 PM, the Administrator stated, We put what we are having for the meal on the whiteboard and then [Dietary Manager (DM)] can also give the residents a printed copy of the menu if the resident would like it. The company says that the whiteboard serves as our menu and that is what we will be serving. We also put on the whiteboard that the menu is subject to change.During an interview on 01/22/26 at 1:27 PM, the Dietary Manager (DM) stated, The menus will vary depending on the supply and demand that we are having to deal with when ordering food. There are some foods that we just cannot get, so we have to adjust the menu. When asked if the DM was aware the registered dietician had to approve the adjustments that are being made with the resident's meals to make sure the residents were receiving the correct amounts of food and within the same food group and he stated, I was not aware of that.Review of the facility's policy Menu Planning dated January 2025 indicated, Menus are planned in advance & [and] [sic] are followed as written, in order to meet the nutritional needs of the residents, in accordance with established national guidelines.2. During a group interview conducted with five Residents (R9, R10, R11, R12 and R13) on 01/21/26 at 10:00 AM, the residents unanimously stated they would like a substantial alternate with each of their meals for each food group. The group stated they were unaware French fries and lettuce, tomatoes, onions and ketchup were on the menu to be served with their 01/20/25 dinner time meal and all indicated, We love French fries! All stated they would have liked to have received the fries and vegetables with their meal. The group stated they were not usually aware of what was on the facility's actual menu, but menu items were posted on a dry erase board in the dining room. The group confirmed substantial alternates were never posted on the dry erase board or anywhere else in the facility, but they all thought they could request a sandwich or a soup if they did not like what (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was being served. The group stated they were never told the fruit served with the 01/20/26 dinner meal was supposed to be apples (rather than pears) and two of the five residents stated pears were served too often and that they did not like pears but were not offered any alternate to the pears when served. The group unanimously agreed they were not notified when the menu changed, but stated they would not know the menu changed to begin with since they were never provided with the facility's actual menu (they were only notified of what was being served by what was printed on the dry erase board in the dining room). Review of R14's Resident Face Sheet, dated 01/22/25 and found in the EMR under the Continuity of Care Document (CCD) Tab, revealed the resident was admitted to the facility on [DATE] with diagnoses included dementia, chronic and acute kidney disease and cellulitis of her left lower limb. Review of R14's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/12/26 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of one out of 15, which indicated severely cognitively impaired. Review of R14's dietary physician's orders, dated 01/15/26 and found in the EMR under the Orders Tab, revealed an order for R14 to receive a regular chopped diet with think liquids. Review of R14's care plan, dated most recently revised 01/16/26 and found in the EMR under the Care Planning Tab, revealed the resident was at risk for significant weight loss. The care plan indicated all foods were to be served a regular diet cut into bite sized pieces. The care plan also indicated R14 required setup and cleanup assistance with meal service and was to be indirectly supervised by staff while eating meals.Review of R14's current diet card/tray card, issued with the resident's meal on 01/21/26 and used by dietary and nursing staff to ensure the resident was receiving her appropriate diet, revealed R14 had no recorded disliked food or fluid and revealed R14 was to receive a soft and bite sized regular diet. On 01/21/26 from 11:35 AM until 12:30 PM, R14 was observed in the dining room eating lunch. A dry erase board next to the kitchen service window indicated chili with beans, baby baked potato, corn bread/dinner roll and grapes were to be served for the meal. At 12:00 PM, R14 was observed being served the chili, a whole bread roll and whole grapes by staff. R14 refused the chili and chicken noodle soup was brought to R14 to replace the chili at 12:15 PM. R14 did not receive potatoes of any kind and R14's bread roll and grapes (large) were served whole. R14 was observed eating bread roll, soup and grapes quickly and independently without staff interaction. During an interview with the Dietary Manager (DM) the DON and the Administrator on 01/22/25 at 12:33 PM, the DM stated R14's roll should have been cut into bite sized pieces and R14 should have been served bananas instead of grapes with the meal. DM stated DM was unable to say why R14 was not served potatoes with the meal and confirmed any dislikes or allergies were to be noted on each resident's tray card. The DM stated the facility should be providing R14 with a diet to meet R14's needs. The DON and Administrator stated they were in agreement R14 should have been served a soft chopped diet and should have received potatoes with the meal and all residents were expected to receive meals to meet their preferences and needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to ensure the kitchen staff prevented contamination of food containers while taking food temperatures and also when the kitchen staff was placing lids on the bowls that contained food the residents would eat. This failure had the potential to increase the risk of foodborne illness for 78 of the facility's 78 residents. During an observation on 01/21/26 at 11:20 AM, Cook1 was observed taking food temperatures of the Chili with Beans, Mashed Potatoes, and pureed Mixed Vegetables. Cook1 was observed to touch the inside of each of these food containers with her bare hand while taking the food temperatures.During an observation on 01/21/26 at 11:28 AM, Dietary Aide (DA)1 was observed touching the inside of the lids with her bare hands while placing the lids on the bowls of Chil with Beans and then placing these bowls on the resident's trays.During an interview on 01/21/26 at 2:01 PM, Cook1 stated, I was not aware that I did that. You are not to touch the inside of the food containers with your hand when you are taking the food temperatures.During an interview on 01/21/26 at 2:14 PM, asked DA1 if she was supposed to touch the inside of the lids when placing them on the bowls of chili with beans. DA1 stated, I don't know.During an interview on 01/22/26 at 1:27 PM, the Dietary Manager (DM) confirmed the kitchen staff were not supposed to touch the inside of the containers of food with their bare hands when taking the food temperatures or when they are placing the lids on the bowls of chili.