

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/09/2026
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 0689 Level of Harm - Actual harm 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** Based on interview and record review, the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R61) reviewed for fall concerns. CNA G (Certified Nursing Assistant) did not utilize a gait belt while transferring R61 in the shower room. R61 fell sustaining a right hip fracture and other injuries. R61 is a 1 person assist with transfers and requires a gait belt. The facility failed to identify that CNA G did not utilize a gait belt for the transfer. As evidenced by: Per OSHA (Occupational Safety and Health Administration) Gait belts, also called transfer belts, are designed to provide caregivers with a secure grip to stabilize patients during transfers, ambulation, or repositioning. OSHA emphasizes safe patient handling to prevent musculoskeletal injuries among healthcare workers, and gait belts are a key component of these safety programs. Facilities are responsible for implementing policies that ensure proper use, training, and compliance with patient care plans and safety standards (OSHA facility guide) .Training and Compliance. Facilities should provide initial and annual refresher training on gait belt use, including hands-on practice and supervision by experienced staff. The facility's policy, Fall Prevention and Management, reviewed 1/2026, indicates in part as follows: Purpose: To assess resident risk for falls and implement interventions to reduce the incidence of falls and/or mitigate the risk of injury related to falls. 3. The Director of Nursing or clinical leader will review post-fall documentation to ensure: A. Data has been collected and documentation is complete B. Contributing factors have been identified C. If intervention/preventive measure is appropriate based on the root-cause of the fall D. Identify if further evaluation or assessment is needed E. Care plan has been updated F. Communication to direct care staff The facility's Orientation Checklist for staff, undated, documents in part as follows: Gait belt usage: Observe, participate in the following: Remember Gait belts are part of your uniform, wear them each day. One person gait belt assist/transfer and ambulation; Two person gait belt assist transfer and ambulation. R61 was admitted to the facility 9/12/24 with diagnoses including but not limited to as follows: fracture humerus surgical neck displaced subsequent with delayed healing right, osteoporosis, and reduced mobility. R61's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R61 scored 14 out of 15 on her Brief Interview for Mental Status (BIMS) indicating she is cognitively intact. R61 is her own person. R61's care plan does not document her transfer status (confirmed as 1 person assist) prior to the fall with fracture. ADON J (Assistant Director of Nursing) edited R61's transfer status to a Hoyer transfer versus resolving and adding a new intervention. Therefore, the previous intervention is not included in the care plan. On 11/27/24 Physical Therapy documented the following order for nursing order for R61: Ambulation: Manual A (assist) of 1 Assistive Device: Walker Special Instructions: Amb (ambulate) with FWW (front wheeled walker) to/from bathroom with A (assist) of 1.* All transfers with FWW (front wheeled (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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents are free of any significant medication errors for 1 of 4 residents (R68) reviewed for medication errors out of a sample of 24. R68 had an order to stop oral chemotherapy medication. R68 was given chemotherapy medications and experienced nausea, weakness, worsening dysphagia, and dizziness. R68 was sent to the emergency room and was found to be significantly more anemic than the week prior. R68 required intervention in the ER when he was given a unit of blood and hospitalized for several days. Evidenced by: This The facility policy entitled, Med Pass, dated 4/2020, states, in part: . III. Medication Error Types: . B. Unauthorized Drug Error: Administration to the patient a dose of medication not authorized for the patient at the time. V. Medication Administration Procedures: . E. General Information: 1. Observe orders to hold drugs. The National Institutes of Health, National Library of Medicine, includes: Etoposide is a medication used in the management and treatment of various cancers. Adverse Effects: Etoposide is a relatively well-tolerated chemotherapeutic agent. Common adverse effects include alopecia and gastrointestinal toxicity. Gastrointestinal toxicity includes: nausea, vomiting, and stomatitis. Immediate concerns include: Myelosuppression: Etoposide's dose limiting side effect is the severe suppression of bone marrow. Administering extra doses when the patient is already weak can plummet white blood cell, red blood cell, and platelet counts. Low white blood cells increase the risk of neutropenic fever, while low platelets increase the risk for bruising and bleeding. Gastrointestinal Distress; potential for increased nausea, vomiting, or mouth sores. R68 admitted to the facility on [DATE]. His diagnoses include Peripheral T-cell lymphoma of lymph nodes of multiple regions, Neoplastic malignant related fatigue, Hemophagocytic lymphohistiocytosis (a severe, life-threatening hyperinflammatory syndrome caused by an overactive immune system that attacks healthy tissues), Bilateral Pulmonary Embolism without heart strain, Deep Vein Thrombosis (serious condition where a blood clot forms in a deep vein), Chemotherapy induced neutropenia, Moderate protein calorie malnutrition, Anemia, and Autoimmune hemolytic anemia with cold gluten syndrome (occurs when your immune system's antibodies attack and destroy your own red blood cells at cold temperatures). R68's Hospital Discharge summary, dated [DATE], includes: Date of Admission- 5/28/26. Date of discharge- 6/19/26. Principal diagnosis- T cell lymphoma, Neoplastic malignant related fatigue, hemophagocytic lymphohistiocytosis, bilateral pulmonary embolism, chemotherapy induced neutropenia, autoimmune hemolytic anemia, anemia, esophageal stricture, physical deconditioning, deep vein thrombosis. Medication list: . Etoposide 50 mg capsule. Commonly known as Vepesid. Take 4 capsules 200mg by mouth 2 times daily. Take only on day 2 and day 3 of each cycle. Follow up with Hematology on 6/23/26. Cycle 2 of chemotherapy scheduled for 6/24/26. Please notify your physician if you experience any of the following: chills, increased confusion, inability to eat/drink/take medication, temperature above 100.4, difficulty breathing, headache, or visual disturbances, pain not relieved by medication, constipation over 48 hours. R68's New Patient Assessment Note, dated 6/23/26, includes: Cancer Center Social Services Intervention. R68 has a new diagnosis of peripheral T-cell lymphoma. He presents today for consultation in Hematology and Medical Oncology. He is accompanied by his friend. R68 was previously hospitalized [DATE]- 6/19/26. R68's Hematology and Oncology Note, dated 6/23/26, includes: After visit summary: . Mobility and function status: Since moving to Skilled Nursing Facility on Friday afternoon, he has had trouble getting around. He can walk to and from the bathroom with help and a walker, but often uses a bedside urinal due to delays in getting assistance. He spends most of the day sitting in a chair and (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	requires help to get up and move. Physical therapy started this morning. Respiratory Symptoms: He feels short of breath when standing up, which he attributes to prolonged bed rest during hospitalization. He has not had any fevers or sweats. Gastrointestinal Symptoms: He has not noticed any bleeding, black or red stools or vomiting. He sometimes experiences belly pain and mild nausea. He had a bowel movement yesterday and is able to pass gas. Nutritional Status: His appetite is very poor and he has not felt hungry in a long time. He has lost 7 pounds in 4 days, with his weight decreasing from 185 pounds six months ago to 155 pounds today. He continues to have trouble swallowing, even after esophageal dilation. He has not had supplemental drinks. but is open to trying them. He is not drinking enough fluids and sometimes goes hours without urinating. He continues to use a spit cup for phlegm. Instructions from MD: Focus on nutrition and supplements, Nutrition Consult, Continue Physical Therapy, PICC line to be placed. will determine based on improvement in functional status, Palliative Care Consult. Today's medication changes: STOP taking: etoposide 50mg capsule, accurate as of June 23, 2026 2:24 PM. Patient seen today in clinic. Delaying treatment until better performance status. Contacted ADON J (Assistant Director of Nursing) to review plan. Facility can draw weekly labs and fax results. They request we fax orders to both faxes. This is complete. Team Registered Nurse will call Skilled Nursing Facility again next week Wednesday to check how he is doing and determine next steps.R68's Nurse Note, dated 6/23/26 at 1:48 PM, includes: Writer received phone call from Oncology nurse. Per nurse they are going to hold off on cancer treatment at this time, due to resident's recent hospitalization. Nurse is going to fax over new weekly lab orders to obtain at facility prior to resident's treatments. She will call each week to check on resident status prior to completing cancer treatments.R68's Nurse Note, dated 6/23/26 at 9:45 PM, includes: Resident returned from his chemotherapy appointment. Apparently, per his representative, resident was too sick to get chemo. Resident returned, sat in chair for supper then was assisted to bed. He had a bed bath as he was too tired to get into the shower.R68's MAR (Medication Administration Record), dated 6/1/26-6/30/26, indicates R68 received Etoposide on 6/25/26 and 6/26/26. Order- 50 mg capsule. Take 4 capsules (200mg) by mouth 2 times daily. Take on Day 2 and Day 3 of each cycle.(note: this medication was to be stopped on 6/23/26 per oncology note)R68's Nurse Note, dated 6/28/26 at 10:17 PM, includes: Resident has been getting Tylenol and Mucinex liquid as needed for complaints of pain and sore throat issues. Both as needed medications worked very well per resident and his representative. His representative stated that she thought the Tylenol was supposed to be scheduled. For now the resident was given medications as needed which has worked well at this time.R68's Nurse Note, dated 6/29/26 at 1:51 PM, includes: Resident's representative requested to have resident's lung sounds assessed as resident was said to be more short of breath. This writer assessed lung sounds and upon auscultation, lung sounds are clear in all lobes for this writer.R68's Nurse Note, dated 6/30/26 at 12:33 PM, includes: Resident felt dizzy while sitting in the chair before lunch. After lunch he went to the bathroom and felt dizzy and got back into bed. This writer asked if he was pushing hard to try and have a bowel movement and he said, No, I was really gassy. I got vital signs. They were 115/63 blood pressure, 111 heart rate, 94% oxygen, 17 respirations, and 99 degrees temperature. Resident was feeling nauseous, but refused any nausea medications. This writer encouraged more fluids. Nurse Practitioner notified and new order: vital signs every shift. Call on call if changes in condition worsen. Nurse Practitioner will see him tomorrow in house. This writer did go back in and discussed with the resident and representative that with him starting chemo medications last Thursday, it is expected to be nauseous and dizzy. And that I really recommend taking one of his as needed nausea medications. Resident agreed to take as needed Compazine. Received at 1:09 PM. Resident and representative agreed to see how he feels after a while in case they want R68 to be (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	sent into emergency room or not.R68's Nurse Note, dated 6/30/26 at 2:21 PM, includes: This writer was helping R68 and his representative figure out what is going on with him. This writer did talk to Charge Nurse and ADON J. The representative called Hematology and had nurse on the phone. I spoke with her and she was concerned that he was not supposed to be on a Chemo medication orally. I looked at his orders and didn't see the Chemo medication due to it being scheduled on cycle of Chemo. We looked at R68's discharge paperwork from when he got here, and the orders were written off of what we received from the hospital. Hematology Nurse said she wanted to talk to a higher up nurse, and I gave her the number for the facility and told her to ask for the Charge Nurse or ADON J. This writer went back in to check on R68 and his representative told me that the Hematology Nurse called her back and was told to bring him to the emergency room and that they alerted the emergency room he was coming. The Hematology Nurse did not call the facility back to talk with Charge Nurse or ADON J, didn't inform of what was going on with this decision. Resident's representative took R68 to the emergency room transferring him by herself due to Hematology Nurse telling her to bring him in. They left at 2:22 PM. Bedhold was signed and emergency room packet was sent with them.R68's Nurse Note, dated 6/30/26 at 3:44 PM, includes: Writer spoke with Hematology Nurse regarding R68's Etoposide administration. No orders for Etoposide were included on the referral paperwork received by the facility on 6/23/26. Hematology Nurse stated the order had been entered into Epic but was not transmitted to our pharmacy. Hematology Nurse also clarified that the recommendation for R68 to be evaluated in the emergency department was based primarily on concerns related to his swallowing ability rather than the delay in chemotherapy administration.R68's MD (Medical Doctor) History and Physical, dated 6/30/26, includes: He was admitted from 5/28/26-6/19/26, initially presenting with weakness, fever, and night sweats. He underwent bone marrow biopsy and was diagnosed with peripheral t-cell lymphoma for which he was started on chemotherapy while admitted . Unfortunately his stay was also complicated by Hemophagocytic lymphohistiocytosis (a severe, life-threatening hyperinflammatory syndrome caused by an overactive immune system that attacks healthy tissues), autoimmune hemolytic anemia with cold gluten syndrome (occurs when your immune system's antibodies attack and destroy your own red blood cells at cold temperatures), bilateral pleural effusions, right lower extremity Deep Vein Thrombosis (serious condition where a blood clot forms in a deep vein) and continued dysphagia secondary to stricture, which is a chronic issue for him. He was discharged to the Skilled Nursing Facility and states that his dysphagia has only gotten worse. He can tolerate minimal by mouth intake at this point. Patient's friend contacts clinic. Reports she feels R68 is going downhill and has questions why he got oral chemo. Reviewed with her that he is not currently on any chemo. She has med technician from Skilled Nursing Facility with her who confirms he received oral Etoposide 6/25/26 and 6/26/26. She states, on his discharge paperwork was to give Etoposide on days 2 and 3 of each cycle. Reviewed with her that patient was seen in clinic since then and chemo was discontinued. Skilled Nursing Facility was updated on this last week on 6/23/26. She asks that I call and speak with ADON J . He was seen on 6/23/26 by hematology and given his worsening performance status, the plan was to hold chemotherapy. Unfortunately, he received oral etoposide on 6/25/26 and 6/26/26 at the Skilled Nursing Facility. He now presents due to his increased weakness and dysphagia and was found to be profoundly more anemic at 5.8 from over 9 a week ago. There are no signs of active bleeding currently other than one dark bowel movement yesterday. It is unclear where the miscommunication occurred in the chain of communication. Since then he has only continued to become more fatigued. In the Emergency Room, he was initially tachycardic to 104 but this did improve to 80s and 90s. He has a friend with him who attends all of his medical appointments as well. They both agree that he has done poorly since leaving the hospital. (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Discussed with . blood bank. They have 2 compatible units currently. Will give one now, but he asks that we hold off on the second unless he decompensates. We discussed his performance status and inability to tolerate by mouth intake. We discussed possible enteral feeding options including G tube. He seems treatment focused at this time. Discussed concern for possible active bleeding in the setting of anticoagulant. Inpatient level of care is appropriate because I am reasonably certain that hospital confinement will be medically necessary for at least two midnights. The medical treatment that will necessitate a stay of this duration is prolonged monitoring of hemoglobin, need for multiple transfusions. The patient was informed that the transfusion involves intravenous administration of the blood product packed red blood cells and does offer a good likelihood of improving anemia. Also discussed were possible problems or difficulties the patient may encounter if treatment was not pursued at this time. These include serious complication of anemia to include death, heart damage and other organ failure, prolonged symptoms of anemia to include shortness of breath and decreased energy level, continued bleeding or increased risk of bleeding.R68's Medication Error Report, dated 6/30/26, includes: date error began- 6/25/26. Date error discovered- 6/30/26. Error discovered by whom- Hematology Registered Nurse. What is the correct order- Etoposide to be discontinued. Describe the error- Resident received medication, though discontinued. Type of error- incorrect medication. Medication error classification- error occurred resulted in need for treatment or intervention. Adverse drug reactions present- complained of dizziness and nausea. Immediate measures taken as directed by the physician- emergency room evaluation. Education provided by ADON J. Notifications- Physician, Pharmacist, Resident.R68's Lab, dated 6/30/26 at 4:14 PM, indicates R68's Hemoglobin is 5.8 (normal limits are 13.6 -16.7g/dl)R68's Lab, dated 6/30/26 at 8:36 PM, indicate R68's Hemoglobin is 5.3 (normal limits are 13.6 -16.7 g/dl)R68's Lab, dated 7/1/26 at 1:34 AM, indicates R68's Hemoglobin is 6.6 (normal limits are 13.6 - 16.7 g/dl)R68's Lab, dated 7/1/26 at 4:39 AM, indicate R68's Hemoglobin is 5.8 (normal limits are 13.6 - 16.7 g/dl)R68's Lab, dated 7/1/26 at 5:35 AM, indicate R68's Hemoglobin is 6.1 (normal limits are 13.6 - 16.7 g/dl)R68's Lab dated 7/1/26 at 11:57 AM, indicates R68's Hemoglobin is 7.1 (normal limits are 13.6 - 16.7 g/dl)On 7/9/26 at 10:29 AM DON B (Director of Nursing) stated, I was the one they notified to say they canceled chemo that day and to increase protein take. From Nurse to Nurse report I was not told to make any other changes just to hold that day. Surveyor asked DON B if she read the paperwork that came back with R68. DON B indicated she had not seen the paperwork. Surveyor and DON B reviewed the paperwork, noting the medication changes section, stating STOP taking: Etoposide 50mg capsule, accurate as of June 23, 2026 2:24 PM. DON B indicated she should have verified the orders.On 7/9/26 at 11:55 AM ADON J indicated R68 should not have received the Etoposide. ADON J indicated Medical Records Clerk S was new and she was just uploading the paperwork and not having a nurse sign off on it. Nurses should look at the incoming paperwork to be sure the orders match what they are told in nurse to nurse report over the phone. If the orders on the paperwork do not match what the nurse was told over the phone, the nurse should call the Provider to clarify the orders. ADON J indicated the facility is not monitoring for adverse reactions or side effects of Etoposide use in Medication Administration Record and there should be. ADON J stated, We never had a conversation with the Provider or Pharmacy to discuss the medication and what to monitor for. On 7/15/26 additional information was received and reviewed; citation remains unchanged.		

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F 0881 Level of Harm - Actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the implementation of an effective antibiotic stewardship program, including adherence to evidence-based criteria and accurate tracking of antibiotic use, for 3 of 10 residents (R3, R13, R97) reviewed for antibiotic therapy. R97 was prescribed an antibiotic the identified organism was resistant to in April 2026. R97 then developed 3 more UTIs over the following weeks and developed resistance to two additional antibiotics. R97 eventually required treatment with IV (intravenous) antibiotics to treat their urinary tract infection. Antibiotic stewardship education was not given to the provider over this time period. R13 was prescribed Cefdinir, an antibiotic, however no sensitivity test was conducted to determine if the antibiotic was effective against the identified organism. R3 was prescribed Ciprofloxacin, an antibiotic to which the culture and sensitivity test indicated the organism was resistant. Findings include: Facility policy entitled, Antibiotic Stewardship Program, last reviewed 2/13/26, states, in part: . b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. 5. As indicated, Nursing will monitor the initiation of antibiotics on residents and reassess continued need and choice of antibiotic to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings. Example 1: R97 was admitted to the facility on [DATE] with diagnoses including left ankle trimalleolar fracture (fractures in three different bones in the ankle creating an unstable joint), type 1 diabetes, and recurrent UTI. The recurrent UTI was diagnosed 2/20/15. On the April 2026 line list, R97 is listed twice for a possible UTI. The infection onset dates are listed as 3/31/26 and 4/20/26. (Of note: There appears to be a missing line list entry for the residents symptoms occurring around 4/12/26 as progress notes indicate that the course of treatment for the infection with the onset of 3/31/26 ended on 4/8/26). The culture and sensitivity, resulted 4/12/26, indicates R97's culture grew a colony count of 50,000 - 90,000 of a multi-drug-resistant organism (MDRO) Klebsiella pneumoniae. The sensitivity indicates that this organism is resistant to ciprofloxacin. On 4/13/26 at 1:44 PM, a Progress Note is written that states, in part: . NP (Nurse Practitioner) aware of lab results. New orders received - start cipro (Ciprofloxacin) PO (by mouth) BID (twice a day) x3 days for UTI. (Of note: This note does not indicate if the Nurse Practitioner was notified that the organism was resistant to the prescribed antibiotic) On 4/14/26 at 11:12 AM, a Progress Note is written that states, in part: IDT Note. Based on culture results antibiotic does not meet McGeers. [Name], NP updated. Continue current POC (Plan of Care). NP referred to urology for further follow up due to frequent UTIs. Culture did grow back with MDRO - ESBL (Enterobacterales - enzyme produced by bacteria that inactivates many common antibiotics) producing bacteria. (Of note: At this time, R97 had received at least two doses of Ciprofloxacin, and the facility was aware the organism was a multi-drug-resistant organism. The note does not indicate if the sensitivity results were discussed at this time). The infection listed with an onset date of 4/20/26 is listed on the April 2026 Facility Event Summary Report indicates these symptoms meet McGeer's criteria. This report also indicates R97 was treated with the antibiotic Augmentin twice a day for 10 days for a UTI. The culture and sensitivity, resulted 4/19/26, indicates R97's culture grew a colony count of greater than a 100,000 of a MDRO, Klebsiella pneumoniae. The sensitivity indicates that this organism has an intermediate sensitivity to Augmentin. (Of note: An intermediate result indicates there is a high likelihood of therapeutic success if the antibiotic exposure is optimized by using higher doses or increased dosing frequency. (continued on next page)		

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F 0881 Level of Harm - Actual harm Residents Affected - Few	Additionally, this culture result does indicate more bacterial colonies of the same organism grew compared to the previous culture.) On 4/21/26 at 2:17 PM, a Progress Note is written that states, in part: IDT Note: Resident restarted on antibiotics for continued UTI. Resident recently completed three day course of antibiotics for UTI. Resident continued to complain of urinary symptoms. Repeat clean catch UA (Urinalysis) obtained and resulted. Resident started on augmentin BID x10 days on 4/20/26. On 5/2/26 at 10:06 AM, a Progress Note is written that states, in part: Resident c/o (complains) of dysuria (pain with urination), and states she's concerned about have a UTI and going septic. She specifically c/o urinary frequency, burning with urination, lower mid-abdominal discomfort and foul smelling urine. Of note. Resident just finished a course of antibiotics for a UTI. When asked if she felt her symptoms ever resolved from her pervious UTI, she stated the symptoms returned as soon as she stopped taking the antibiotic. On call provider. notified of resident's request for a UA. The infection listed with an onset date of 5/2/26 is listed on the May 2026 Facility Event Summary Report indicates these symptoms meet McGeer's criteria. This report also indicates R97 was treated with the antibiotic Macrobid for a UTI. The culture and sensitivity, resulted 5/7/26, indicates R97's culture grew a colony count of greater than a 100,000 of a MDRO, Klebsiella pneumoniae. The sensitivity indicates that this organism has an intermediate sensitivity to Macrobid.(Of note: R97 prescribed Augmentin following the last culture and sensitivity result indicating R97 had an intermediate sensitivity to the antibiotic. This culture and sensitivity indicates R97 is now resistant to Augmentin.) On 5/6/26 at 3:15 PM, a Progress Note is written that states, in part: Provider notified of resident's culture results. Received new order. Start Macrobid 100 mg (milligram) capsule BID x 7 days for UTI. On 5/16/26 at 7:02 AM, a Progress Note is written that states, in part: Resident continues this overnight shift w/ (with) c/o [sic] frequent urination w/ little to no output and burning upon urination. Resident states it is not uncommon to have continuing UTI s/s (signs and symptoms) even after being treated for a UTI. Resident states she has previously required IV (intravenous) ABX (antibiotics) for UTI, as tablet forms of medication are usually ineffective. On 5/16/26 at 10:51 AM, a Progress Note is written that states, in part: Resident continued to c/o to this writer of burning/painful urination, frequency and urgency. Resident expressed concerns about having UTI and [sic] possibly a MDRO as resident has had one in the past that needed IV ABX. This writer reached out to on call physician. and received orders to obtain a UA and C&S. The culture and sensitivity, resulted 5/18/26, indicates R97's culture grew a colony count of greater than a 100,000 of a MDRO, Klebsiella pneumoniae.(Of note: R97 prescribed Macrobid following the last culture and sensitivity result indicating R97 had an intermediate sensitivity to the antibiotic. This culture and sensitivity indicates R97 is now resistant to Macrobid.) On 5/18/26, a Progress Note is written that states, in part: UA results received and routed to Dr. If worsening clinical symptoms or unstable vitals, to present to ED (Emergency Department) for IV ertapenem (antibiotic). Resident received first IV antibiotic today in infusion center. On 7/9/26 at 12:40 PM, Surveyor interviewed NP (Nurse Practitioner) P. Surveyor asked NP P what her process is for selecting which antibiotic to use to treat a UTI. NP P indicates she always uses the culture and sensitivity results to drive the treatment plan. NP P also notes antibiotics also get brought up in the interdisciplinary team meetings. Surveyor asked NP P how she receives culture and sensitivity results. NP P indicates the lab results are sent to both the NP P's and the facility's electronic health record. NP P also indicates that facility staff are good at updating her with lab results; however, she is aware that on-call physicians may have been responsible for ordering antibiotics and may not always order culture and sensitivity tests. On 7/9/26 at 8:25 AM, Surveyor interviewed RCD (Regional Clinical Director) C and IP (Infection Preventionist) O. RCD C notes IP O took over the infection preventionist role around a month prior to the survey (continued on next page)		

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F 0881 Level of Harm - Actual harm Residents Affected - Few	entrance date (7/6/26) and that RCD C was assisting with infection control prior to IP O's appointment. Surveyor asked RCD C and IP O what standard of practice the facility uses for determining if an infection should be treated. RCD C indicates McGeer's criteria. Surveyor asked IP O how the facility assesses residents for antibiotic appropriateness. IP O indicates the facility utilizes McGeer's criteria to determine if an infection should be treated, he remains in contact with the provider regarding antibiotic coverage, he runs a report on antibiotic use and trends, and if they are new admissions, he requests the culture and sensitivity results from the hospital. Surveyor asked if R97's culture and sensitivity results were discussed with a provider following indication that the organism was resistant to the ordered antibiotic. RCD C indicates the progress notes say the Nurse Practitioner was updated on the lab results. Surveyor asked RCD C if the notes indicate education was provided. RCD indicates, no, however there is an IDT note that indicates R97's recurrent UTIs were discussed, and a urology appointment was scheduled. Example 2: R13 was admitted to the facility on [DATE] with diagnoses including age-related osteoporosis (bone demineralization causing fragile and weak bones) with current right femur pathological fracture, schizophrenia, and dementia. On the April 2026 line list, R13 is listed as having a UTI with signs and symptoms listed as agitation and pain or burning with urination. The line list also indicates test results of more than 50,000 bacteria and white blood cells present. The Facility Event Summary Report indicates R13's McGeer's Criteria, dated 4/16/26, does not meet criteria for a UTI. R13's urinalysis was completed on 4/14/26, however no culture and sensitivity was completed. R13 was prescribed the antibiotic cefdinir, 300 MG (milligrams) twice a day for 7 days for a UTI (urinary tract infection) On 7/9/26 at 12:40 PM, Surveyor interviewed NP (Nurse Practitioner) P. Surveyor asked NP P if anyone had ordered a culture and sensitivity following R13's urinalysis result which was dated 4/14/16. NP P indicates a culture and sensitivity was not completed, and she is not sure why, however she does note there was an electronic system change at that time which may have caused some issues. Surveyor asked NP P if she would expect facility staff to contact her if culture and sensitivity results indicated the organism was resistant to the ordered antibiotic. NP P states yes and acknowledges that it is also her responsibility to verify results as well. On 7/9/26 at 12:40 PM, Surveyor interviewed NP (Nurse Practitioner) P. Surveyor asked NP P if R3 should have been prescribed an alternative antibiotic as their culture and sensitivity results indicate the organisms were resistant to the ordered Ciprofloxacin. NP P indicates it is hard to say since multiple organisms were included in the culture. On 7/9/26 at 8:25 AM, Surveyor interviewed RCD (Regional Clinical Director) C and IP (Infection Preventionist) O. Surveyor asked RCD C since R13's sensitivity never resulted, if that should have been discussed with the Nurse Practitioner when they ordered the antibiotic. RCD C indicates this was reviewed with the medical director on 4/16/26 according to the progress notes. Surveyor asked RCD C if she attends the QAPI meetings and knows if antibiotic stewardship education was given to the providers. RCD C indicates she does not attend QAPI meetings so is unsure what specifically was discussed. Example 3: R3 was admitted to the facility on [DATE] with diagnoses including a left femur (bone forming the thigh and connecting the hip to knee) fracture, type 2 diabetes, retention of urine, and other obstructive and reflux uropathy (urine cannot flow normally or flows backwards). On 5/19/26, R3 had a culture and sensitivity (lab conducted to identify specific microorganisms and check the effectiveness of various antibiotics against that organism) result with three organisms: Morganella morganii, Pseudomonas aeruginosa, and Enterococcus faecalis. Morganella morganii and Enterococcus faecalis were resistant to the antibiotic Ciprofloxacin. R3's physician orders indicate they were treated with Ciprofloxacin. R3 had a second urinalysis and culture and sensitivity, which resulted on 5/24/26, finding the organism Morganella morganii which was also (continued on next page)		

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F 0881 Level of Harm - Actual harm Residents Affected - Few	resistant to Ciprofloxacin.(Of note: The facility was unable to provide documentation indicating provider education or consultation occurred following the culture and sensitivity results.)On 7/9/26 at 8:25 AM, Surveyor interviewed RCD (Regional Clinical Director) C and IP (Infection Preventionist) O. Surveyor asked RCD C if any provider education on antibiotic stewardship was given when R3 was started on an antibiotic the organism was resistant to in May 2026. RCD C states, no. Surveyor asked RCD C if antibiotic stewardship education should have been provided at that time. RCD C states, yes.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 70 residents who reside in the facility. Surveyor observed staff turning wet dishware upside down on a tray creating a seal and not allowing the dishware to air dry completely. Surveyor observed food to be in circulation past the use by date. Surveyor observed an unclean mixer stored under a plastic covering. Evidenced by: Example 1 Facility policy, titled Handling of Leftover Food, revised 1/2025, includes: Leftovers should be covered, labeled, dated, and refrigerated as soon as the tray line is finished. Refrigerated leftovers should be used within 3 - 7 days after opening. On 7/6/26 at 10:45 AM Surveyor observed the following food to be in the facility's walk in refrigerator past the use by date: barbeque chicken with use by date of 7/5/26, sweet and sour sauce with use by date of 6/30/26, creamed corn with use by date of 7/3/26, and baked beans with use by date of 7/3/26. During interview, RCD C (Regional Clinical Director) indicated the food should have been discarded on the use by date if it was not used. Example 2 On 7/6/26 at 10:45 AM Surveyor and RCD C (Regional Clinical Director) observed a mixer to be stored under a plastic covering. RCD C lifted the plastic and food debris was observed on the under carriage. RCD C indicated the mixer should have been cleaned before being covered in plastic. Example 3 Facility policy, titled Dish Machine High Temperature, revised 1/2025, does not include procedures for dishwashing. The eFDA Food Code, section 4-901.11, states: After cleaning and sanitizing equipment and utensils: must be air dried. On 7/8/26 at 9:34 AM Surveyor and RCD C observed dishware, including mugs, cups, and bowls on the clean side of the dishwasher to be placed upside down on plastic trays. RCD C turned over several pieces of dishware. Surveyor and RCD C observed liquid to be trapped inside and unable to air dry completely. Dietary Manager E joined the observation and during interview he indicated dishware should be allowed to air dry completely before stacking or turning upside down.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, this has the potential to affect the census of 70. The facility did not monitor residents with potentially infectious symptoms. The facility policies do not indicate what data should be collected for the residents with potentially infectious symptoms. CNA R (Certified Nursing Assistant) did not complete hand hygiene per standards of practice while providing perineal care for resident (R21). This is evidenced by: Facility policy entitled, Monitoring Infection Control Practices, last reviewed 2/13/26, states, in part: . Policy: The facility's Infection Control Preventionist will conduct routine monitoring and surveillance to determine compliance with infection control policies and practices. Procedures: If suspicion or evidence of an infection is detected within the resident population the following should be done. 7. The facility's Infection Control Preventionist will collect data and enter information into facility's electronic data program. Example 1 The facility's line lists, used for infection surveillance, dated April 2026 to May 2026 do not contain residents who showed signs and symptoms of a potential infection. In April 2026, R95 was experiencing signs and symptoms of a urinary tract infection including incontinence and dysuria (painful urination). R95 had a urinalysis (test used to assess for urinary tract infections and kidney function) and the nurse practitioner decided not to treat based on the urinalysis results. R95 was not included on the April 2026 line list. In April 2026, R27 was experiencing a runny nose. The facility completed a COVID test and a chest x-ray. R27 was not included on the line list. (Of note: R27 was also not included in the Facility Event Summary Report which lists each resident's McGeer's Criteria Assessment which provides guidelines for surveillance and treatment of infections.) In May 2026, R49 was tested for a urinary tract infection with urinalysis. R49 was not included on the line list. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/9/26 at 8:25 AM, Surveyor interviewed RCD (Regional Clinical Director) C and IP (Infection Preventionist) O. RCD C notes IP O took over the infection preventionist role around a month prior to the survey entrance date (7/6/26) and that RCD C was assisting with infection control prior to IP O's appointment. Surveyor asked RCD C and IP O what the process is for determining which residents are added to the line list. RCD C indicates that residents are only added to the line list if they meet McGeer's criteria. IP O indicates that's also his current practice. Surveyor asked RCD C and IP O how the facility tracks residents who are symptomatic but may not yet meet criteria at the time of assessment. RCD and IP O indicate the facility does not track the residents if they don't meet McGeer's criteria. (Of note: Facility infection control policies do not indicate what type of data should be collected, such as infection type, pathogen, signs and symptoms, etc.) Example 2: The Morbidity and Mortality Weekly Report dated 10/25/02 and published by the CDC (Centers for Disease Control and Prevention) entitled, Guideline for Hand Hygiene in Health Care Settings, Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Further guidelines indicated recommendations to wash hands after touching a patient or patient's surroundings. The above information can also be found at: https://www.cdc.gov/handhygiene/providers/index.html with the page last reviewed on February 27, 2024. On 7/8/26 at 9:30 AM, Surveyor observed CNA R (Certified Nursing Assistant) and CNA Q (Certified Nursing Assistant) provide perineal care to R21. Surveyor observed CNA R move R21's bed with her gloved hands. Surveyor observed CNA Q open R21's brief. CNA R stated to R21, I'm going to pull back your scrotum. Surveyor observed CNA R lift R21's scrotum. CNA R did not doff (remove) her gloves after touching items in R21's environment (bed), perform hand hygiene and don (put on) clean gloves prior to assisting with R21's perineal care. On 7/8/26 at 9:40 AM, Surveyor spoke with CNA R (Certified Nursing Assistant). Surveyor asked CNA R when you should sanitize/wash your hands. CNA R stated, before and after removing gloves. Surveyor asked CNA Q should you have removed your gloves, sanitized your hands, and donned clean gloves after touching R21's bed and prior to pulling back R21's scrotum. CNA R stated, she is sorry and did not even think about it. CNA R stated, yes, she should have. On 7/9/26 at 8:48 AM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B when she expects staff to sanitize/wash their hands. DON B stated, when entering a resident room, exiting the room, between cares, removing gloves, before and after glove use and basically all the time. Surveyor asked DON B if a staff member touches items in the resident's environment with gloved hands prior to doing perineal care would you expect staff to remove their gloves, sanitize their hands, and apply clean gloves. DON B stated, yes. Surveyor shared the observation of CNA R not changing her gloves, sanitizing/washing hands and applying clean gloves prior to performing perineal care with R21. DON B stated that CNA R should have removed her gloves, sanitizer hands and donned clean gloves after touching R21's bed and prior to performing perineal care.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure the required contents of the Notice of bed-hold policy and return was provided with the bed hold notice for 4 of 4 residents (R39, R53, R68, R9) reviewed for hospitalizations out of a sample of 24 Residents. R39 had an incomplete bed hold notice for 3/8/26 and 5/26/26. R53 had an incomplete bed hold notice for 6/15/26. R68 had an incomplete bed hold notice for 6/30/26. R9 was sent to the hospital on 2/5/26. The bed hold provided to R9 did not include the reason for transfer or include resources available for the resident. R9 was sent to the hospital on 4/8/26. The bed hold provided did not include resources available to resident. This is evidenced by: Per the State Operations Manual, The written notice must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged ; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. The Facilities Policy and Procedure entitled Bed Hold dated 01/25 does not speak to what the bed hold notice requirements are. Example 1 R39's bed hold dated 3/8/26 does not include the reason for discharge, the location to which R39 was transferred, the appeal rights, Ombudsman contact information or other Advocacy Agency contact information. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's bed hold dated 5/26/26 does not include the reason for discharge, the location to which R39 was transferred, the appeal rights, Ombudsman contact information or other Advocacy Agency contact information. Example 2 R53's bed hold dated 6/15/26 does not include the reason for discharge, the location to which R53 was transferred, the appeal rights, Ombudsman contact information or other Advocacy Agency contact information. Example 3 R68's bed hold dated 6/30/26 does not include the reason for discharge, the location to which R68 was transferred, the appeal rights, Ombudsman contact information or other Advocacy Agency contact information. Example 4 R9 was admitted to the facility on [DATE], and has diagnoses that include Diabetes Mellitus Type 2, Acquired absence of right leg below knee and cellulitis of right lower limb. R9's Quarterly Minimum Data Set (MDS) Assessment, dated 6/11/26, shows R9 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R9 is cognitively intact. R9's Bed Hold, dated 2/05/26 does not indicate the reason for the transfer nor does it provide the resident with resources available to assist with the financial aspect of holding the bed. R9's Bed Hold, dated 4/08/26 does not provide the resident with resources available to assist with the financial aspect of holding the bed. On 7/8/26 at 11:13 AM, Surveyor interviewed RN M (Registered Nurse). Surveyor asked RN M what is sent with a resident when they go to the hospital, RN M said there's a document on the computer that includes payor source information, contact information, medication list, diagnosis list, allergy list, most recent vital signs, immunizations, and parts of the care plan. Surveyor asked RN M who completes the bed hold form when a resident must go to the hospital, RN M replied the nurse does, usually verbally. Surveyor asked RN M if there is anything else that goes with a resident when they go to the hospital, RN M indicated a large 9x11 envelope that includes a transfer form and a bed hold form. RN M also stated the residents' original POST form also goes with them. On 7/8/26 at 5:03 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the bed hold notices should include all the required information (where to, why, resources, etc.) and be completely filled out, DON B stated yes.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not always serve food that was palatable and served at the right temperature. This has the potential to affect 1 of 1 sampled Residents (R33) and 2 of 2 supplemental residents (R17 and R79), and 1 of 1 test trays. This has the ability to affect more than a minimal number of Residents. Surveyor performed a test tray, and the results were not palatable. R79, R33, and R17 voiced concerns of their hot meals being served to them at cold and undesirable temperatures. During the Resident Council Group, residents voiced the coffee is always cold and residents do not get menus. Evidenced by: Facility policy, titled Food Temperature Records/Control, revised 1/25, includes: The temperature of all foods on serving line will be measured prior to resident service. Cold foods should be 41 degrees F (Fahrenheit) or less. Hot foods should be between 135-165 degrees F. Example 1 On 7/08/2026 from 11:45 AM to 12:01 PM Surveyor observed resident lunch trays in an insulated cart with the door open. On 7/8/26 at 12:02 PM Surveyor observed the first room tray to be passed from the insulated cart. On 7/8/26 at 12:12 PM Surveyor was served a test tray and recorded the following temperatures: spaghetti bake- 109 degrees F (Fahrenheit), zucchini-108 degrees F. coffee-119 degrees F, and cottage cheese 54 degrees F. On 7/8/26 at 12:30 PM Regional Clinical Director C indicated the door should not be left open on the insulated cart with the hot meals in it and the temperatures of the hot foods is too cool and the cottage cheese was too warm. Example 2: R79 admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 6/7/26 indicates R79's cognition is severely impaired with a BIMS (Brief Interview for Mental Status) score of 9 out of 15. On 7/9/26 at 7:59 AM during an interview, R79 indicated she gets served scrambled eggs at a cool and undesirable temperature at times. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 R33 was admitted to the facility on [DATE] and has diagnoses that include Traumatic Brain Injury and Adjustment Disorder. R33's admission Minimum Data Set (MDS) Assessment, dated 3/30/26, shows R33 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R33 is cognitively intact. On 7/06/26 at 2:50 PM, Surveyor interviewed R33. R33 indicated the food is atrocious. The menus do not match what is served. R33 indicated he wants frosted flakes every morning for breakfast and it is listed on his meal card. R33 indicates he does not get frosted flakes every morning and he will have to ask for them. R33 indicated it is upsetting and frustrating. R33 indicated that the coffee is never hot, it is always cold. The portion sizes are small. The meals are consistently cold. Example 4: On 7/06/26 at 1:34 PM, during the Resident Council Group with Surveyors, residents voiced the coffee is always cold and the residents do not get menus. Residents voiced concern that the toast is served dry and they must ask for butter if they want it. The time they get the butter the toast is cold. Example 5 R17 is a short-term resident of the facility. R17's most recent MDS (Minimum Data Set) dated 7/2/26 documents that R17 scored a 15 on her BIMS (Brief Interview of Mental Status), which indicates intact cognition. On 7/7/26 at 10:58 AM, Surveyor asked R17 how the food is here, R17 said the food is alright. Surveyor asked R17 if meals are received in the room or dining room, and R17 replied room. Surveyor asked R17 if her hot foods come hot and her cold food comes cold, R17 stated I never get coffee or tea hot. On 7/8/26 at 3:37 PM Dietary Manager E indicated hot meals should be served at a safe and desirable temperature and cold foods should be served at a cold and desirable temperature.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not follow through with the appropriate steps of the PASARR (Preadmission Screening and Resident Review) process for 3 of 5 residents (R8, R9 and R72) reviewed for PASARR screening out of 24 sampled Residents. R8 had a Level 1 PASARR screening completed with a 30-day exemption request. The facility did not have a level II PASARR screening completed at the end of the 30-day exemption. R9 had a Level 1 PASARR screening completed with a 30-day exemption request. The facility did not have a level II PASARR screening completed at the end of the 30-day exemption. R72 did not have a level two PASRR (Preadmission Screening and Resident Review) completed. Evidenced by: The facility policy, entitled Pre-admission admission Process, dated 1/25, states, in part: Standard: Social Services will evaluate each resident's psychosocial and behavioral needs during the pre-admission process. Policy: Social Services will review each potential resident's psychosocial and behavioral needs and Pre-admission Assessment and Annual Resident Review (PASARR). 2. Social Services will ensure that the referring party obtains a Level 2 PASARR screening, when indicated. 3. Social Services will determine the needed facility services and programs to meet the potential resident's psychosocial and behavioral needs based upon pre-admission assessment and PASARR information. Example 1: R8 was admitted to the facility on [DATE], and has diagnoses that include Vascular Dementia, Post Traumatic Stress Disorder, Bipolar Disorder and Borderline Personality Disorder. R8's Minimum Data Set (MDS) admission Assessment, dated 4/28/26, shows R8 has a Brief Interview of Mental Status Score (BIMS) of 12, indicating R8 has moderate cognitive impairment. Surveyor reviewed R8's Level 1 PASRR screening which indicated the facility answered Yes to the question Does the person have a major mental disorder? The facility entered Yes for Hospital Discharge Exemption- 30 Day Maximum. The facility answered No to Is the person staying longer than the permitted exemption period? (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2: R9 was admitted to the facility on [DATE] and has diagnoses that include Major Depressive Disorder. R9's MDS Quarterly Assessment, dated 6/11/26 shows R9 has a BIMS score of 15 indicating R9 is cognitively intact. Surveyor reviewed R9's Level 1 PASSR screening which indicated the facility answered Yes to the question Does the person have a major mental disorder? The facility entered Yes for Hospital Discharge Exemption- 30 Day Maximum. The facility answered No to Is the person staying longer than the permitted exemption period? Example 3 R72 is a short-term resident of the facility. R72 admitted with the following diagnoses: generalized anxiety disorder, major depressive disorder, and bipolar disorder. R72 had a level one PASRR completed on 1/19/26 and documents a 30-day exemption (indicating that R72 will only reside in the facility for 30 days). R72 is prescribed an antipsychotic medication, quetiapine. On 7/08/26 at 12:59 PM, Surveyor interviewed SS F (Social Services) and asked if R8, R9 and R72 have a Level 2 PASRR. SS F reviewed the medical records and indicated no. Surveyor asked SS F what the process is for obtaining PASRRs. SS F indicated for every resident admitted a Level 1 is completed and forwarded to Forward Health. When a Level 2 screening is required the facility receives a notice from the state. Forward Health completes the Level 2 screening. Once the Level 2 screening is completed the facility receives a report on the findings of the Level 2 and a copy of the Level 2. The Level 2 screening then goes into the resident's medical record. Surveyor asked what the process is for a 30-day exemption. SS F indicated another Level 1 screening would be completed at the end of the 30 days and submitted again to Forward Health. Forward Health would complete the Level 2 and the facility would receive a copy 1 to 3 weeks later. Surveyor asked if R8 should have had a Level 2 screening completed at the end of the 30-day exemption and placed in the medical record. SS F indicated yes. Surveyor asked if R9 should have had a Level 2 screening completed at the end of the 30-day exemption and placed in his medical record. SS F indicated yes. Surveyor asked SS F if R72 should have had a Level 2 screening completed at the end of the 30-day exemption and placed in his medical record. SS F indicated yes. Surveyor asked SS F who is responsible for ensuring the process for obtaining PASRRs is followed through. Surveyor referred Surveyor to the Quality Assurance Nurse. On 7/08/26 at 1:23 PM, Surveyor interviewed QAN L (Quality Assurance Nurse) who indicated he is responsible for auditing all residents, before admission or on the day of admission, have a Level 1 completed. QAN L indicated that the social worker would be responsible for obtaining Level 2 screenings. QAN L asked RCD C (Regional Clinical Director) if she was able to find out if the Level 2 screenings were completed but not uploaded into the system. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/08/26 at 2:02 PM, RCD C indicated the Level 2 screenings were not completed for R8, R9 and R72. Surveyor asked RCD C if she would expect all residents with a 30-day exemption to have a Level 2 screening completed at the end of the 30-day exemption. RCD C indicated yes, and the facility does not have the Level 2 screenings.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that services provided by the facility meet professional standards of quality for 2 of 5 residents (R8 & R44) reviewed for unnecessary medications. R8 is receiving Melatonin for insomnia and did not have a sleep assessment completed. R44 did not have any kind of assessment completed prior to or on a regular basis after beginning a sleep aid. Evidenced by: The facility policy entitled, Psychotropic Medication Use, dated 1/2026, states, in part: . Policy: Residents are not given psychotropic medication unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record. Policy Explanation and Compliance Guidelines: 1. Psychotropic medications include, but are not limited to: antipsychotics, antidepressants, anti-anxiety, and hypnotics. 2. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening may be used to determine indications for use of psychotropic medications ordered upon admission to the facility. c. Psychotropic medications will be initiated after other causes have been ruled out or addressed, and nonpharmacological interventions have been attempted. 8. Medications that have a documented use that appears to be a substitution for a psychotropic medication are subject to the same requirements as psychotropic medications. Note: Surveyor asked RCD C (Regional Clinical Director) for policy on sleep aides or sleep assessments. RCD C indicated there are no policies on sleep aides or assessments, just the psychotropic policy. Note: Surveyor asked RCD C (Regional Clinical Director) for policy on sleep aides or sleep assessments. RCD C indicated there are no policies on sleep aides or assessments, just the psychotropic policy. Example 1: (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8 was admitted to the facility on [DATE] and has diagnoses that include Insomnia. R8's admission Minimum Data Set (MDS) Assessment, dated 4/28/26 shows that R8 has a Brief Interview of Mental Status (BIMS) Score of 12 indicating R8 has moderate cognitive impairment. R8's Physician Orders, dated for 6/08/26-7/08/26, states, in part: .Melatonin tablet; 3 milligrams (mg) amount: 9 mg oral. Special instructions: Administer 3 tablets (9mg) by mouth at bedtime for nocturnal calming. Start Date: 4/28/26 End Date: Open Ended. R8 did not have a sleep assessment completed related to melatonin use. On 7/07/26 at 3:00 PM, Surveyor interviewed RCD C (Regional Clinical Director) and asked for a sleep assessment for R8's melatonin use. RCD C indicated the facility does sleep aide monitoring on side effects of the medication and log the hours of sleep each shift on the medication administration record (MAR). RCD C indicated those are started on the MAR when the sleep aide starts or if a resident is admitted on a sleep aide. RCD C indicated the facility does not do sleep assessments prior to starting a sleep aide. On 7/09/26 at 8:33 AM, Surveyor interviewed DON B (Director of Nursing) and asked what the process is for starting a resident on a sleep aide. DON B indicated the facility does side effect monitoring and hours of sleep every shift. Surveyor asked DON B what the process for a new admission is admitting with a sleep aide ordered. DON B indicated it is the same. Surveyor asked DON B if the facility does sleep assessments for residents before starting them on a sleep aide. DON B indicated no. Surveyor asked if R8 has a sleep assessment and DON B indicated no. Example 2 R44 is a long-term resident of the facility. R44 has orders for melatonin 3 mg (milligrams) QHS (every bedtime) for nocturnal calming. This medication was started on 11/4/24. R44 does not have any kind of sleep assessment documented. On 7/9/26 at 8:26 AM, Surveyor interviewed RN M (Registered Nurse). If a resident complains of insomnia, what do you do with that information, RN M said he'd check the MAR (medication administration record) to see if they had an order for some type of medication and review their care plan to see if there are any non-pharmacological interventions to try. Surveyor asked RN M if a sleep assessment is completed before starting a sleep aid, RN M replied not a formal document, no. On 7/9/26 at 8:31 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would expect a sleep assessment to be done prior to a resident starting on a sleep aid, DON B indicated that many residents come into the facility already on them. Surveyor asked DON B if there should be a sleep assessment, DON B said they monitor the number of hours a resident sleeps each shift.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure it had procedures in place to assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each resident for 2 of 4 residents (R33 & R3) out of 24 sampled Residents. R33 had a scheduled colonoscopy with instructions to hold Eliquis prior to procedure. The facility administered R33's Eliquis and the colonoscopy had to be cancelled due to the Eliquis given. The facility did not follow physician orders resulting in a medication error. R3 received new orders to increase his losartan, and this medication was not provided per physician orders. Evidenced by: The facility policy entitled, Med Pass, dated 4/2020, states, in part: . III. Medication Error Types: . B. Unauthorized Drug Error: Administration to the patient a dose of medication not authorized for the patient at the time. V. Medication Administration Procedures: . E. General Information: 1. Observe orders to hold drugs. Example 1: R33 was admitted to the facility on [DATE], and has diagnoses that include Adjustment Disorder, Long Term use of Anticoagulants, and Central Cord Syndrome at C5 level of the spinal cord. R33's admission Minimum Data Set (MDS) Assessment, dated 3/30/26, shows that R33 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R33 is cognitively intact. Gastroenterology and Hepatology Orders, dated 5/11/26, states: . Type of Procedure: Colonoscopy Date of Procedure: 6/11/26. Blood Thinners: Eliquis message sent 5/6/26 to hold 48 hours. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Education completed: Educated [NAME] charge nurse [[NAME]] on 5/26/26. R33's Physician Orders, dated 5/09/26 & 6/09/26, states, in part: . Eliquis (apixaban) tablet; 2.5 milligrams (mg); amount: 2.5 mg; oral. Special Instructions: Administer 2.5 mg by mouth BID (twice a day) for recurrent DVT (Deep Vein Thrombosis) . R33's Medication Administration Record (MAR), dated 6/1/26-6/30/26, shows R33 received Eliquis 2.5 mg on: 6/9/26- AM & PM (2 times) 6/10/26- AM & PM (2 times) 6/11/26- AM & PM (2 times) Of note: Order was to hold Eliquis 48 hours prior colonoscopy on 6/11/26. R33's Progress Note, dated 6/11/26 at 10:11 AM, states, in part: Received a phone call from [Mayo Health System] stating that they are unable to do the colonoscopy due to him receiving his Eliquis last night. They will call back to reschedule another time. On 7/06/26 at 2:50 PM, Surveyor interviewed R33. R33 indicated he was to have a colonoscopy twice. The first time the bowel prep was not effective. The second time the facility administered the blood thinner that was to be held for the colonoscopy. R33 indicated he was told by the facility that [Mayo] did not call in the orders to the facility to hold the blood thinner. R33 indicated he reached out to his provider to question the instructions. The provider forwarded the documentation between the provider and the charge nurse at the facility regarding the instructions to hold the Eliquis prior colonoscopy. R33 showed Surveyor the email which confirmed the facility had indeed received the instructions for the colonoscopy. Surveyor asked R33 if he had the colonoscopy. R33 indicated no. R33 indicated he is not going through the prep again; two times was enough. On 7/09/26 at 10:35 AM, Surveyor interviewed DON B (Director of Nursing) and asked what the process is for ensuring instructions/orders received for scheduled diagnostic tests are carried through. DON B indicated the DON, ADON (Assistant Director of Nursing) or the charge nurse receives the fax with the instructions for whatever test is ordered. The information is then entered into the MAR to ensure the orders are carried out by the nurses. DON B indicated the instructions are also put on the 24-hour board. Surveyor asked DON B if she would expect physician orders to be followed. DON B indicated yes. Surveyor reviewed R33's notes regarding the colonoscopy scheduled for 6/11/26 and orders to hold the Eliquis. Surveyor asked DON B if the order was put on R33's June MAR to hold the Eliquis per colonoscopy instructions. DON B indicated no. Surveyor asked if the orders should have been transcribed onto R33's MAR for the scheduled 6/11/26 colonoscopy, and DON B indicated yes. Surveyor asked DON B if the Eliquis was administered 6/9/26-6/11/26, and DON B indicated yes and (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it should not have been. Surveyor asked DON B if this is a medication error. DON B indicated yes. Example 2: Facility policy, titled Med Pass, initiated 4/2020, includes: .Medication error- a dose of medication, which deviates from the physician's drug order on the patient chart. Medication Error Types: . Wrong dose error-Any dose constituting the wrong number of preformed dosage units and/or above or below the correct dose by 50% or more. R3 admitted to the facility on [DATE] with diagnoses, including Type 2 Diabetes Mellitus and Hypertensive Heart Disease. R3's Physician Orders, dated 6/1/26-6/30/26, include: start date- 11/18/25: Losartan tablet 50mg (milligrams), oral. once a day by mouth for Hypertension. R3's Physician Handwritten Order, dated 6/10/26, includes: Increase Losartan to 75 mg by mouth daily, manual blood pressure 2 times a week, review blood pressure on 7/1/26. R3's Clinic Outpatient Detail Report, dated 6/10/26, includes: Losartan 50 mg tablet. Take 1.5 tablets/75 mg by mouth daily for high blood pressure. Receipt confirmed by pharmacy on 6/10/26 at 9:47 AM. R3's Nurse Progress Note, dated 6/10/26 Received new order from Nurse Practitioner to increase Losartan to 75 mg by mouth daily, manual blood pressure 2 times a week, review blood pressure on 7/1/26. R3's Physician Orders, dated 6/1/26-6/30/26, updated to: Start date 6/11/26 Losartan tablet 50mg, amount to administer 75mg, oral. Give 1.5 tablets/75 mg total by mouth daily for Hypertension. R3's Medication Administration Record, dated 6/1/26-6/30/26, indicates R3's Losartan was administered as ordered from 6/1/26-6/23/26. R3's Medication Regimen Review, dated 6/23/26 at 11:36 AM, includes: (Monthly) Medication orders reviewed by Pharmacist. Medication dose, frequency, route of administration and duration are appropriate for resident's condition, manufacturer's recommendations and standards of practice. Losartan was increased, but pharmacy did not receive order. Will ask facility to send order again and will update provider. June labs reviewed, sodium improved with discontinuation of HCTZ. Med Therapy Recommendation: Losartan was increased on 6/10/26, but pharmacy did not receive order. Pharmacy has been supplying 50mg tabs every morning. Please send dose increase to pharmacy. Thank you. (It is important to note the medication was not being distributed by the pharmacy in the dose of 75mg. The pharmacy was only supplying 50mg tablets every morning and had not received the order. Nurses were signing out that they were giving 75mg from 6/11/26-6/23/26 while only giving 50mg tablets.) (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/26 at 8:15 AM Surveyor asked Med Technician/CNA T (Certified Nursing Assistant) about R3's Medication Regimen Review and his Physician orders. Med Technician/CNA T and [NAME] President of Clinical Services U indicated the facility maybe did not send the medication order to the correct pharmacy and staff just kept signing it out while giving R3 the 50 mg doses. On 7/9/26 at 3:16 PM VP of Clinical Services U stated, This is a medication error. He only got 50 mg until the day the pharmacy brought the medications, after 6/23/26. A report should have been filled out. IDT (Interdisciplinary Team) should have looked into this. She needs to notify R3's MD (Medical Doctor) about this and I educated her today.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident's drug regimen was free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications (R8). R8 is receiving Trazodone for Insomnia. The facility failed to complete a sleep assessment prior to starting the medication. Evidenced by: The facility policy entitled, Psychotropic Medication Use, dated 1/2026, states, in part: . Policy: Residents are not given psychotropic medication unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record. Policy Explanation and Compliance Guidelines: 1. Psychotropic medications include, but are not limited to: antipsychotics, antidepressants, anti-anxiety, and hypnotics. 2. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening may be used to determine indications for use of psychotropic medications ordered upon admission to the facility. c. Psychotropic medications will be initiated after other causes have been ruled out or addressed, and nonpharmacological interventions have been attempted. 8. Medications that have a documented use that appears to be a substitution for a psychotropic medication are subject to the same requirements as psychotropic medications. R8 was admitted to the facility on [DATE] and has diagnoses that include Insomnia. R8's admission Minimum Data Set (MDS) Assessment, dated 4/28/26 shows that R8 has a Brief Interview of Mental Status (BIMS) Score of 12 indicating R8 has moderate cognitive impairment. R8's Physician Orders, dated for 6/08/26-7/08/26, states, in part: . Trazodone tablet; 100 milligrams (mg); amount: 200 mg; oral. Special Instructions: Give (2) 100 mg tabs = 200 mg total by mouth daily at bedtime for insomnia. Start Date: 4/28/26 End Date: Open Ended. R8's Care Plan, dated 7/07/2026, states, in part: . Problem Start Date: 7/07/26. Insomnia Goal: Long Term Goal Target Date: 10/07/26 Resident will have at least 6 hours sleep per night. Approach: .-Administer medication per MD Order. Approach Start Date: 7/07/26.-Sleep study as needed. Approach Start Date: 7/07/26. R8's Medication Administration Record (MAR) for 4/2026 shows R8 received Trazodone for Insomnia 4/28/26- 4/30/26. R8's MAR for 5/2026 shows R8 received Trazodone for Insomnia 5/1/26- 5/31/26. R8's MAR for 6/2026 shows R8 received Trazodone for Insomnia 6/1/26- 6/31/26. R8's MAR for 7/2026 shows R8 received Trazodone for Insomnia 7/1/26- 7/08/26. On 7/07/26 at 3:00 PM, Surveyor interviewed RCD C (Regional Clinical Director) and asked for a sleep assessment for R8's Trazodone use. RCD C indicated the facility does sleep aide monitoring on side effects of the medication and log the hours of sleep each shift on the medication administration record (MAR). RCD C indicated those are started on the MAR when the sleep aide starts or if a resident is admitted on a sleep aide. RCD C indicated the facility does not do sleep assessments prior to starting a sleep aide. On 7/09/26, at 8:33 AM, Surveyor interviewed DON B (Director of Nursing) and asked what the process is for starting a resident on a sleep aide. DON B indicated the facility does side effect monitoring and hours of sleep every shift. Surveyor asked DON B what the process for a new admission is admitting with a sleep aide ordered. DON B indicated it is the same. Surveyor asked DON B if the facility does sleep assessments for residents before starting them on a sleep aide. DON B indicated no. Surveyor asked if R8 has a sleep assessment and DON B indicated no.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide food that accommodates resident preferences; appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice for 1 of 1 sampled resident's (R33). R33 voiced concerns he does not receive his preferences as specified on meal tickets unless he asks for them. Evidenced by: The facility policy entitled, Nutritional Assessment, dated 1/25, states, in part: . Policy: A nutritional assessment will be completed on all residents within 5-14 days of admission. Procedure: 1. Collect Data: A. Complete Nutritional Assessment Form in EMR (electronic medical record). 1. Assessment form includes: . f. Collecting likes/dislikes. Communicate Data: 1. Document nutrition related problems and approaches. 2. Communicate recommendations in writing to nursing. 6. Transfer appropriate information to computerized tray card and/or food service staff. R33 was admitted to the facility on [DATE] and has diagnoses that include Traumatic Brain Injury and Adjustment Disorder. R33's admission Minimum Data Set (MDS) Assessment, dated 3/30/26, shows R33 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R33 is cognitively intact. R33's Physicians Orders, dated 6/10/26, states, in part: . Diet- Regular with thin liquids. Start Date: 3/24/26 End Date: Open Ended. I authorize the facility's appointed qualified dietician/qualified nutrition profession who is acting within their scope of practice as defined by State Law the task of writing dietary orders while under the supervision of this physician. Start Date: 3/24/26 End Date: Open Ended. R33's Meal Card, dated 7/07/26 shows R33 would like Frosted Flakes daily for breakfast. On 7/06/26 at 2:50 PM, Surveyor interviewed R33. R33 indicated the food is atrocious. The menus do not match what is served. R33 indicated he wants frosted flakes every morning for breakfast and it is listed on his meal card. R33 indicates he does not get frosted flakes every morning and he will have to ask for them. R33 indicated it is upsetting and frustrating. On 7/08/26 at 11:04 AM, R33 requested to see this Surveyor. Surveyor went to speak with R33 and he indicated he did not get his frosted flakes again this morning. R33 indicated he had told the cna (certified nursing assistant) and she went to the kitchen to get them and brought the frosted flakes to R33. On 7/08/26 at 11:38 AM, Surveyor interviewed CNA N . CNA N indicated R33 did not get his frosted flakes this am and she had to go to the kitchen to get them for R33. Surveyor asked if R33 is to receive frosted flakes every morning with breakfast. CNA N indicated yes, it is on his meal card to receive frosted flakes every morning with breakfast. On 7/08/26 at 3:40 PM, Surveyor interviewed DM E (Dietary Manager) and asked what the process is for collecting and honoring residents' preferences. DM E indicated during intake DM E or the supervisor completes a preference sheet. The preferences are transferred onto the residents' meal slips. Surveyor asked how the dietary staff and nursing staff are made aware of their preferences. DM E indicated he verbally communicates it to the staff and it is changed on the meal slips. The meal slips are sent out on the residents' meal trays with meals. Surveyor asked DM E if he would expect residents' preferences to be honored. DM E indicated yes. Surveyor informed DM E of R33's concern with not receiving frosted flakes every morning for breakfast and the interview with CNA N about R33 not receiving frosted flakes this morning. On 7/09/26, at 8:33 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor informed DON B of R33's concern about not receiving frosted flakes every morning for breakfast, which is listed on R33's meal slips. Surveyor asked DON B if she would expect R33's preference for frosted flakes to be honored. DON B indicated yes.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 1 of 26 sampled residents (R53) for change of condition. The facility did not maintain a complete medical record for R53. Evidenced by: Facility policy, titled Clinical Record policies, reviewed 1/2026, includes: . The clinical record shall contain information to identify the resident clearly, a record of the resident's assessments, the plan of care and services, the results of pre-admission screening, and progress notes which indicate changes towards achieving care plan objectives. In addition, the resident's clinical record shall be readily accessible and systematically organized to facilitate retrieving and compiling information. The purpose of the clinical record is to document events through the course of the resident's stay. To provide a medium of communication among health care professionals involved in the resident's plan of care, to provide supportive documentation for reimbursement purposes, to service as a basis for evaluation of the facility's quality of care, to assist in protecting the facility's residents and health care providers' legal interests. Physician's progress notes are entered into the record at the time of each visit and signed and authorized by the physician. Progress notes, assessments, observations, medication and treatment records- In the resident's medical record as events occur in each facility department, documents will be authenticated and dated and may include. notation of physician visit, notation of resident's visits to clinics, hospitals, . notations of unusual incidents or accidents or actions taken. R53 admitted to the facility on [DATE] with the following diagnoses, including Type 2 Diabetes Mellitus, Malignant neoplasm of liver and intrahepatic bile, Acute Myocardial Infarction, and Chronic Obstructive Pulmonary Disease. R53's Progress Notes, dated 6/10/26 at 1:11 PM, includes: Received a phone call from hospital stating they are keeping him overnight due to low oxygen saturation and pain management. (Transportation company) was notified and ride was canceled. Resident is currently hospitalized at this time. Wound measurements not obtained due to hospitalization. (It is important to note RX's medical record did not contain notes from this hospital stay or the clinic visit where RX had the following procedure: IR Microwave Ablation with CT Guidance Liver.) R53's Progress Notes, dated 6/15/26 at 12:06 PM, includes: Resident is being admitted back to the facility today. Transportation and accompanied by a public transportation company. Resident is being discharged today from hospital with primary diagnosis of acute respiratory failure after having an IR microwave ablation procedure done. Resident transfers and ambulates with assist of 1 with a wheeled walker and gait belt. Last bowel movement was 6/15/26. Diet was changed to a carb controlled with thin liquids. On 7/6/26 at 4:00 PM Surveyor asked RCD C (Regional Clinical Director) to assist Surveyor with finding information regarding R53's clinic visit and/or hospitalization, dated 6/10/26. RCD C indicated she was unable to locate it in R53's record, but maybe it was not scanned in yet and she would talk with Medical Records. On 7/7/26 at 4:00 PM Surveyor asked RCD C for copies of R53's clinic visit or hospital visit, dated 6/10/26. RCD C indicated she was working on it. Surveyor asked if the facility had access to the Epic system. RCD C indicated they should. On 7/8/26 at 9:20 AM DON B brought Surveyor copies of R53's clinic visit and hospitalization for the time frame of 6/10/26-6/15/26. DON B indicated these should have been in R53's Medical Record, but there was staff turnover in the Medical Records Department. On 7/8/26 at 1:03 PM Medical Records Clerk S indicated R53's documentation from the clinic and the hospital should have been scanned into his record and wasn't. Medical Records Clerk S indicated if it (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/09/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was scanned in it would have a stamp on it that says scanned with a date. On 7/8/26 at 1:11 PM RCD C indicated either R53 didn't bring the paperwork to facility staff or facility staff didn't print them and scan them in. RCD C stated, Either way they should have been there.		