STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525212	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wisconsin Rapids Health Services	1350 River Run Dr Wisconsin Rapids, WI 54494

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 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, staff and resident interview, and record review, the facility did not ensure food was stored, prepared, and served in a safe and sanitary manner. This practice had the potential to affect 35 of 36 residents residing in the facility (one resident received nutrition via tubefeeding.)Staff did not complete appropriate hand hygiene.Documentation logs for parts per million (PPM) of the sanitizing solution were not completed correctly.Staff did not follow safe food cooling protocols.Food was not served at an appropriate temperature.Findings include:On 2/23/26 at 9:40 AM, Surveyor and Account Manager (AM)-E began an initial kitchen tour. AM-E stated the facility follows the Food and Drug Administration (FDA) Food Code.Hand Hygiene:The 2022 FDA Food Code documents at 2-301.14: Food Employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles.The 2022 FDA Food Code documents at 3-301.11 Preventing Contamination from Hands: (A) Food Employees shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, Food Employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.The facility's undated Handwashing Policy indicates: Proper handwashing, by far, is the single most important thing you can do to prevent infections and stop the spread of infectious disease. The most important thing to remember is that you can never over wash your hands. You should wash your hands frequently - and at least every 15-20 minutes. Most important times to wash hands: After using the restroom; returning from breaks; sneezing, coughing or blowing your nose; smoking; eating; drinking; using chemicals; handling trash; cleaning; touching your own or someone else's clothing or hair; touching any unsanitized surface .The facility's Food Preparation policy, revised 9/2017, indicates: All food is prepared in accordance with the FDA Food Code. All staff will practice proper hand washing techniques and glove use.On 2/24/26 at 7:40 AM, Surveyor observed Dietary Aide (DA)-I serve food from the second floor kitchenette. DA-I grabbed plates and touched food serving utensils with bare hands. DA-I served food on the plates that DA-I had touched. At 7:43 AM, Surveyor observed DA-I pick up a plastic single-use cup cover off the floor with bare hands and put it in a garbage can. Without completing hand hygiene, DA-I continued to serve food and touch plates with bare hands. At 7:49 AM, Surveyor observed DA-I open the door to the hallway with a bare hand. DA-I then continued to serve food and touch plates with bare hands. The process continued until all residents on both floors were served.On 2/24/26 at 7:54 AM, Surveyor interviewed DA-I who stated DA-I should complete hand hygiene throughout meal service and after picking refuse off the floor and touching door handles.On 2/24/26 at 8:55 AM, Surveyor interviewed AM-E who stated staff should complete hand hygiene throughout meal service, when picking refuse off the floor, and after touching high-touch surfaces.Sanitizing Solution:The 2022 FDA Food Code documents at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the Environmental Protection Agency (EPA)-registered label use instructions.The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.The Ecolab Oasis 146 Multi-Quat Sanitizer data sheet indicates the sanitizing solution should be tested for effectiveness by measuring the PPM dilution range. Hydrion Quat test strips are the appropriate testing strips. The sanitizing solution temperature needs to be tested and within 65-75 degrees Fahrenheit (F). The effective PPM range is 150-400 PPM.The facility's policy, revised 6/2025, indicates: All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition .2. The Dining Services Director will ensure employees are knowledgeable in the proper procedures for cleaning and sanitizing food service equipment and surfaces .The facility's Manual Warewashing Policy, revised 9/2017, indicates: .2. Appropriate test strips will be used to measure the concentration of the sanitizing solution. Results will be recorded on the Three-Compartment Sink log.On 2/24/26 at 9:09 AM, Surveyor observed a container of Ecolab Oasis 146 Multi-Quat Sanitizer in the kitchen and an Ecolab Oasis 146 Multi-Quat Sanitizer data sheet posted above the three-compartment sink. Surveyor also observed a bucket of sanitizing solution inside a bin of ice near the sink.On 2/24/26 at 9:15 AM, Surveyor asked DA-J to test the PPM of the sanitizing solution. DA-J stated the sanitizing solution was put on ice because AM-F told DA-J to cool the solution. DA-J stated it was the first time DA-J had to cool the solution and indicated the solution came out hot and was usually used that way. DA-J left the area and did not test the PPM.On 2/24/26 at 9:18 AM, Surveyor reviewed the facility's Sanitizer Bucket log which contained columns to record the time, PPM, and initials of staff who performed the test 4 times daily (twice on each AM and PM shift). The log did not contain a column to record the temperature of the sanitizing solution. Surveyor noted the bottom of the log indicated the Ecolab Oasis 146 Multi-Quat Sanitizer had an efficacy range of 150-400 PPM. The form also indicated staff should refer to the manufacturer's guidelines along with state and local requirements. The log indicated if the chemical concentration does not meet the manufacturer's established parameters, staff should stop using it and alert a manager or designee. In addition, Surveyor noted 10 columns over 5 shifts in the previous 4 days were blank. The 5:30 AM shift test was also missing on 2/24/26.On 2/24/26 at 9:20 AM, Surveyor interviewed AM-E who stated the sanitizing solution is usually hot when it comes out of the three-compartment sink. AM-E stated an Ecolab professional was at the facility the day before and informed management that staff need to temp the sanitizing solution prior to use. AM-E stated the Ecolab professional stated staff should cool the sanitizing solution on ice to bring it to the appropriate testing and use temperature. AM-E indicated staff should test the sanitizing solution and document the results on the log twice per shift as indicated on the log.On 2/24/26 at 9:24 AM, Surveyor asked [NAME] (CK)-K to test the sanitizing solution. Surveyor observed CK-K dip a Hydrion test strip in the solution and remove the strip after approximately a half second to one second. CK-K held the test strip to the PPM guide on the back of the container. CK-K stated the color guide indicated the PPM were 200. Surveyor observed CK-K test the temperature of the sanitizing solution which was 76 degrees F (and outside of the 65 to 75 degree testing range). Surveyor and CK-K discussed the testing process and reviewed the Hydrion test strip packaging and an Ecolab Oasis 146 Multi-Quat Sanitizer data sheet posted above the three-compartment sink. CK-K indicated CK-K had completed the test wrong. Surveyor observed CK-K redo the test. The temperature was within the appropriate temperature range and the PPM were 400. CK-K stated it was a new process for CK-K who did not know CK-K was supposed to temp the sanitizing solution before that day. When asked if CK-K had ever reviewed the Oasis 146 Multi-Quat Sanitizer data sheet posted above the three-compartment sink, CK-K stated CK-K did not know.On 2/24/26 at 1:49 PM, Survey received a sanitizing log from AM-H who showed Surveyor that the log had a column for the temperature to be tested along with the PPM. AM-H indicated to Surveyor that staff will be trained on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the process and will use the sanitizing log moving forward.Food Cooling Temperatures:The 2022 FDA Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celcius (C) (135 Fahrenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less.The 2022 FDA Food Code documents at section 3-501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods.The facility's Food Preparation policy, revised 9/2017, states: All food is prepared in accordance with the FDA Food Code .4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time food items are exposed to temperatures greater than 41 degrees and/or less than 135 degrees F or per state regulation .16. Prepared hot food items that are not intended for immediate service will be cooled using the following guidelines: Place in shallow pans or cut/slice to promote rapid cooling. Time/Temperature Control for Safety (TCS) foods will be cooled from 135 degrees F to 70 degrees F within two hours. TCS foods will be cooled from 70 degrees F to 41 degrees F within four hours. Total cooling time cannot exceed 6 hours. The clock starts at 135 degrees F .During an initial kitchen tour that began at 9:40 AM on 2/23/26, Surveyor interviewed AM-E who indicated the facility saves leftovers and uses a cooling log to document the cooling process. Surveyor and AM-E reviewed the facility's February 2026 food cooling log which contained 17 items. Surveyor noted only 3 of the items were tracked to 41 degress F or less. Fourteen items were listed between 43 degrees F and 67 degrees F which was in the TCS food danger zone. Surveyor also noted 32 of 34 time entries on the form ended in 00 which indicated every test was completed at the top of the hour which AM-E verified was unlikely. AM-E stated follow-up and retraining on food cooling and documentation was needed.On 2/24/26 at 7:37 AM, Surveyor interviewed [NAME] President of Success (VPS)-G who stated VPS-G made an executive decision that morning that the facility would no longer save leftovers and, therefore, would no longer use a food cooling log.Food Holding Temperatures:The facility's Food Preparation policy, revised 9/2017, indicates: All food is prepared in accordance with the FDA Food Code .4. The Dining Services Director/Cook(s) are responsible for food preparation techniques which minimize the amount of time food items are exposed to temperatures greater than 41 degrees and/or less than 135 degrees F or per state regulation .11. When hot pureed, ground, or diced foods drop into the danger zone (below 135 degrees F), the mechanically-altered food must be reheated to 165 degrees F for 15 seconds if holding for hot service .13. All food will be held at an appropriate temperature, greater than 135 degrees F (or as state regulation requires) for hot holding, and less than 41 degrees F for cold holding .On 2/24/26 at 7:40 AM, Surveyor observed DA-I serve residents from the second floor kitchenette. Surveyor noted most of the hot food was served from the steam table. Surveyor observed a pan of ground meat on a rolling cart; the meat was not in the steam table and was not kept warm. At 7:50 AM, Surveyor observed DA-I put a serving of ground meat from the cart on a plate with other food from the steam table. The ticket indicated the meal was for R45. DA-I gave the plate to staff to deliver to R45. DA-I indicated the meat was ground sausage and verified the sausage had not been kept warm. DA-I indicated the cooks put the ground sausage on the rolling cart and DA-I did not know why. When asked if R45 was going to be served room temperature sausage, DA-I stated yes unless staff microwaved it downstairs.On 2/24/26 at 8:55 AM, Surveyor interviewed AM-E who indicated DA-I should have kept the ground sausage hot and not served it to R45 at room temperature. AM-E indicated DA-I should have made room for the sausage in the steam table.On 2/24/26 at 10:28 AM, Surveyor interviewed R45 who stated R45's breakfast was fair. R45 stated the sausage was not warm and R45 did not care for sausage.On 2/24/26 at 12:57 PM, Surveyor (continued on next page)

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	525212	A. Building B. Wing	02/25/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interviewed Nursing Home Administrator (NHA)-A who stated kitchen staff should know and follow hand hygiene, sanitizing solution testing, food cooling, and hot holding policies. NHA-A was aware that VPS-G implemented a new protocol for no leftovers. NHA-A indicated staff recently received hand hygiene education from AM-H.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 staff interview and record review, the facility did not provide a bed hold or transfer notice and/or notify the state long-term care Ombudsman of hospital transfers for 2 residents (R) (R19 and R21) of 5 sampled residents. R19 was transferred to the emergency room (ER) on 9/25/25, 10/5/25, and 1/8/26. R19 was not provided a written bed hold or transfer notice for the hospital transfers on 9/25/25 and 1/8/26. In addition, the Ombudsman was not notified of any of the transfers.R21 was transferred to the ER twice on 1/18/26. The Ombudsman was not notified of the transfers. Findings include:The facility's Transfer and Discharge policy, revised 7/15/22, indicates: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except as initiated by the resident, necessary for the health and safety of the resident or other individuals are endangered, or as otherwise permitted by applicable law. Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility .7. Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident: .K. The Social Services Director/designee shall provide notice of transfer to a representative of the state long-term care Ombudsman via a monthly list. 1. From 2/23/26 to 2/25/26, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including right below knee amputation, urinary tract infection (UTI), chronic obstructive pulmonary disease (COPD), bladder neck obstruction, peripheral vascular disease (PVD), and neuromuscular dysfunction of the bladder. R19 had an indwelling urinary catheter. R19's Minimum Data Set (MDS) assesment, dated 1/3/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R19 had intact cognition. R19 made R19's own healthcare decisions.A Nurse Practitioner's (NP) note, dated 10/2/25 at 9:00 AM, indicated R19 was sent to the ER on [DATE] due to blood in the urine, decreased urinary output, and possible kidney issues. An NP note, dated 10/23/25 at 10:45 AM, indicated R19 was sent to the ER for UTI and dehydration on 10/5/25.An NP note, dated 1/13/26 at 10:45 AM, indicated R19's indwelling catheter was removed on 10/25/25 for a voiding trial. The catheter was reinserted on 10/28/25. On 1/8/26, R19 saw a Urologist who removed the catheter with instructions to reinsert the catheter if R19 could not void more than 12 hours later. R19 was unable to void and refused to have the catheter replaced. R19 was in pain and had moderate bleeding from the tip of the penis. R19 was sent to the ER.R19's medical record did not indicate bed hold or transfer notices were provided to R19 for the hospital transfers on 9/25/25 and 1/8/26. Surveyor also reviewed a binder that contained monthly reports sent to the Ombudsman and noted the Ombudsman was not notified of R19's hospital transfers on 9/25/25, 10/5/25, and 1/8/26.On 2/25/26 at 9:29 AM and 10:52 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified R19 was not provided bed hold or transfer notices for the hospital transfers on 9/25/25 and 1/8/26. NHA-A also verified the binder did not contain Ombudsman notification for R19's 9/25/25, 10/5/25, and 1/8/26 hospital transfers. 2. From 2/23/26 to 2/25/26, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following a stroke, diabetes, and nontraumatic hematoma of soft tissue right leg wound. R21's MDS assessment, dated 2/15/25, had a BIMS score of 11 out of 15 which indicated R21 had moderate cognitive impairment. R21 made R21's own healthcare decisions.A nursing progress note, dated 1/18/26 at 3:00 PM, indicated R21 was transferred to the ER around lunch time due to a large round raised hematoma that continued to swell and cause severe pain. R21 returned to the facility with orders to follow-up with R21's primary care provider in 2 weeks and keep R21's bilateral lower extremities elevated and wrapped in ace wraps. A nursing progress note, dated 1/18/26 at 7:44 PM, indicated R21 was transferred to the ER again due to increased swelling of the right lower leg (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hematoma, uncontrolled pain, restlessness, and small blisters. Surveyor reviewed a binder that contained monthly reports sent to the Ombudsman and noted the Ombudsman was not notified of R21's hospital transfers on 1/18/26.On 2/25/26 at 10:54 AM, Surveyor interviewed NHA-A who verified the Ombudsman was not notified of either of R21's hospital transfers on 1/18/26.

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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 staff interview and record review, the facility did not monitor for adverse reactions to a high risk medication for 1 resident (R) (R32) of 5 sampled residents.R32 had an order for Apixaban (an anticoagulant) 5 milligrams (mg) two times daily for cerebrovascular accident (CVA). The facility did not monitor R32 for adverse reactions to the high-risk medication. In addition, R32 did not have a care plan related to anticoagulant use.Findings include:The facility's High Risk Medication policy, dated 8/30/23, indicates: The resident's care plan should alert staff to monitor for adverse consequences. Risks associated with anticoagulants include but are not limited to: a. Bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool); b. Fall in hematocrit or blood pressure; c. Thromboembolism.From 2/2326 to 2/25/26, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including long-term (current) use of anticoagulants, history of venous thrombosis and embolism, and cognitive and communication deficit. R32's Minimum Data Set (MDS) assessment, dated 12/10/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R32 had moderately impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC).R32's medical record contained an order for Apixaban 5 mg two times daily for cerebrovascular accident. R32's medical record did not indicate R32 was monitored for adverse reactions to the high-risk medication and did not contain a care plan for anticoagulant use. On 2/24/26 at 3:05 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated staff should monitor for abnormal bleeding, bruising, or black stools for residents on anticoagulant medication. LPN-D stated anticoagulant monitoring should be on a resident's care plan and Treatment Administration Record (TAR). LPN-D verified R32 did not have monitoring interventions or a care plan for anticoagulant use.On 2/25/26 at 2:16 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R32 did not have monitoring interventions in place or a care plan for the use of anticoagulant medication.