STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525354	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineral Point Health Services	109 N Iowa St Mineral Point, WI 53565

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 2 of 3 residents (R6 and R3) reviewed. R6 was taking aspirin, the facility failed to monitor for signs and symptoms of bleeding, failed to notify the physician about their change of condition, and failed to complete an assessment when R6 had a change of condition. R3, who has CHF (Congestive heart failure) was admitted with orders for daily weights and the facility did not conduct these weights to monitor her condition. The facility also did not contact the physician immediately upon a severe weight change. Evidenced by: The facility's policy titled Change in Condition of the Resident last reviewed on 9/20/22 states in part .When a resident presents with a possible change of condition, after a fall or other possible trauma, or noted changes in mental or physical functioning: 1. Assess the resident's need for immediate care/ medical attention. Provide emergency care as needed. 2. Assess/ evaluate the resident. The assessment/ evaluation could include, but is not limited to, the following: a. Vital signs, oxygen saturation, blood glucose level.c. Swelling, edema, discoloration.e. Personality, behavioral and/or cognitive changes. f. Alteration in level of consciousness, ability to respond.h. Sensory weakness or change. I. Generalized or local weakness.o. Bleeding.q. Dyspnea or irregular breathing.3. Notify the resident's physician- Use INTERACT Change in Condition: When to report to the MD/NP/PA (Medical Doctor/ Nurse Practitioner/ Physician Assistant) as a guideline. a. Immediate notification: Immediate notification for any symptom, sign or apparent discomfort that is: i. Acute or sudden onset, and: ii. A marked change (i.e., more severe) in relation to usual symptoms and signs, or iii. Unrelieved by measures already prescribed requires a phone call to the provider. 5. Monitor resident's condition frequently until stable or transported to a higher level of care, if needed.Documentation: Documentation needs to include, but is not limited to the following: 1. Description of change in condition noted and assessment or observation of findings. 2. Emergency care provided, if appropriate. 3. Notification of provider- include date, time, what was conveyed, any orders received (each time notified). 4. Notification of responsible party.5. Names and titles of employees involved with resident's care at that time. The facility's policy titled High Risk Medications- Anticoagulants dated 8/30/23 states in part .4. The resident's plan of care shall 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 (blood clot). 5. The resident's plan of care shall include interventions to minimize the risk of adverse (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 0684 Level of Harm - Actual harm Residents Affected - Few	consequences. According to a post on Harvard Health Publishing dated 10/1/21, Aspirin decreases the ability of tiny cell fragments in the blood, called platelets, from clumping together and forming clots. Preventing these clots will help you avoid a repeat heart attack. Aspirin inhibits substances that protect the stomach's delicate lining, which can provoke bleeding in the stomach and intestines. If you notice stomach upset or pain, call your doctor. Taking aspirin with food may help. Older people and others prone to bleeding may want to ask their physician about taking an over-the-counter proton-pump inhibitor such as omeprazole (Prilosec), which can help prevent aspirin-induced stomach bleeding. More serious bleeding in the gastrointestinal tract can manifest as black, tarry stools. In rare cases, you may vomit dried blood (which resembles coffee grounds) or fresh blood. These situations should be evaluated right away in an emergency room. Aspirin and bruising - Harvard Health State of Wisconsin, Chapter N6 Standards of Practice for Registered Nurses and Licensed Practical Nurses, states in part: N 6.03 Standards of practice for registered nurses. (1) General nursing procedures. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s or UAPs. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis . Example 1 R6 was admitted to the facility on [DATE] with diagnoses that include heart disease, type 2 diabetes mellitus, squamous cell carcinoma of skin and neck (skin cancer), and long-term aspirin use. R6's most recent MDS (Minimum Data Set) dated 4/24/26 states that R6 has a BIMS (Brief Interview of Mental Status) of 6 out of 15, indicating that R6 is severely cognitively impaired. R6's MDS also indicates that they are dependent on staff for all their ADLs. R6's care plan dated 2/16/26 states in part .Focus: Cardiac disease r/t (related to) essential hypertension, hx of CVA (history of stroke), atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm (plaque buildup in coronary arteries causing angina, often worsened by coronary artery spasms), thoracic aortic ectasia (mild, uniform widening of the thoracic aorta that is less than 50% greater than its normal diameter and carries a lower immediate (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	risk than an aneurysm), long term use of aspirin, venous insufficiency.Interventions/Tasks: Administer medications as ordered. Encourage rest periods as needed. Obtain lab results as ordered and notify physician of results. Obtain vital signs as indicated; report changes to physician. Obtain weights as needed/ ordered; report significant change. Tubi Grips ON AM OFF HS (bedtime). R6's Physician orders include: Aspirin Oral Tablet Delayed Release 81 mg (milligrams) Give one tablet by mouth one time a day for prophylaxis, CVA (stroke) prevention. Start date: 2/1/23. On 5/28/26 at 8:42 AM, Surveyor interviewed LPN K (Licensed Practical Nurse). Surveyor asked LPN K what do you monitor for when a resident is receiving a blood thinner/ anticoagulant, LPN K stated bruising, bleeding, and blood in the urine. Surveyor asked LPN K if that monitoring is typically found on the MAR/TAR (Medication Administration Record/Treatment Administration Record), LPN K stated yes. Surveyor asked LPN K if R6 had that type on monitoring on their MAR/TAR prior to their hospitalization on 4/1/26, LPN K reviewed R6's MAR/TAR and reported that there wasn't any monitoring listed. It is important to note that R6's care plan and MAR/TAR (Medication Administration Record/ Treatment Administration Record) do not include directions for staff to monitor R6 for signs and symptoms of bruising and bleeding due to aspirin use. Nurses' notes state the following: On 4/1/26 at 5:14 AM: Resident requesting to get up to the bathroom but is too weak to stand in the sit to stand lift. Color is pale and voice is weak. Temp (temperature) is normal O2 sats 99% on room air. Resident has a congested cough coughing up clear phlegm. It is important to note that there is no assessment completed, no documented vital signs, and no documentation of physician notification regarding this change of condition. On 5/28/26 at 2:48 PM, Surveyor interviewed RN L (Registered Nurse). Surveyor asked RN L if they were working with R6 on 4/1/26, RN L stated yes. Surveyor asked RN L to explain R6's change of condition, RN L reported that in the morning, there were 2 CNAs (Certified Nursing Assistants) that were going to transfer them and reported that R6 was really weak, and he was coughing up phlegm, and was pale. Surveyor asked RN L if they completed and documented any type of assessment on R6, RN L stated no and that they passed it on to the next shift to monitor. Surveyor asked RN L if they notified the physician of R6's change of condition, RN L stated no and they passed it on to the day shift nurse. On 4/1/26 at 8:13 AM: Communication with physician: Resident showing shortness of breath and oxygen sats ranging in the 70's. Oxygen placed at 2L/min which improved sats to 81%. Afebrile. Respirations 32 breaths per minute. Lung sounds absent in RLL (right Lower Lobe). Skin pale and resident appears gaunt. On-call physician [MD Name] gave orders to send to ER (Emergency Room) for eval and tx (evaluation and treatment) . [Ambulance Company Name] transferred resident at 0810 (8:10 AM) to [Hospital Name]. SBAR (Situation, Background, Assessment, Recommendation) Communication Form completed by DON B (Director of Nursing) dated 4/1/26 at 7:35 AM states in part .Situation.Shortness of breath.Vital Signs: BP (Blood Pressure) 124/99 Pulse: 54 RR (Respiratory rate): 32 Temp 98.0.O2 81% .Appearance: .Resident became very weak. Skin pale. Oxygen sats out of range, oxygen applied at (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2L/min (liters/minute) and improved to 81%. No respiratory distress noted but respirations 32. Right lower lobe lung sounds absent. 4/1/26 at 2:51 PM: [R6's Son's name] son called this nurse with a report. Resident is staying at [Hospital Name] for observation d/t (due to) being severely anemic. Resident has received [sic] 2 units of blood at this time and condition is improving. Abnormality noted in rectum by hospitalist. ED (Emergency Department) note dated 4/1/26 at 8:47 AM states in part Chief Complaint: Patient presents with cough, shortness of breath- Developed cough in the night, staff at facility say he has been coughing up lots of junk and his O2 (oxygen level) sats have been in the upper 70's, patient keeps saying he feels like it's his time to leave us. History of Present Illness: [R6's Name] is a [R6's age] male presenting with not feeling well. For the past 2 days he hasn't been eating, noting stomach pain, nausea. No fevers but was noted to be coughing during the night and they found low O2 sats. He is unsure if he has had blood in his stools. He currently denies pain, says he feels a little SOB ([NAME] of breath). No cough noted. He vomited what looks like blood tinged emesis on the way in. He says he has not eaten today.ED Triage Vitals: Temp 97.8, Pulse 108, Resp (Respirations) 28, BP (Blood Pressure) 77/46, O2 96% .Physical Exam: .Appearance: He is ill- appearing.Comments: Pale, thin/ cachectic.Mouth: Mucous membranes are dry. Comments: Tongue is pale. Eyes: .Comments: Conjunctival pallor (noticeable lack of pink or red coloration in the conjunctiva, the mucous membrane lining the inner surface of the eyelids) noted. Cardiovascular: Rate and Rhythm: Tachycardia (elevated heart rate) present. Rhythm irregular. Pulmonary: .Mild tachypnea (fast breathing). Abdominal: .There is abdominal tenderness. Genitourinary: Rectum: Guaiac result positive (stool positive for blood) .Skin: Coloration: Skin is pale.Neurological: .Weakness (generalized) present. ED Labs: CBC (Complete Blood Count) with Auto Differential: WBC (White Blood Cells) 19.3 (H(High)), RBC (Red Blood Cells) 2.00 (L(Low)), Hemoglobin 6.2 (LL(Lower Limit)), Hematocrit 19.7 (LL).Critical Care Documentation: The patient has a critical illness or injury that acutely impairs one or more vital organs systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. The patient's care requires complex decision making, monitoring and interventions to prevent clinical deterioration.Critical care Conditions: Shock/Hypotension: Acute anemia requiring blood transfusion.Disposition: Observation: Floor. Condition: Serious. Diagnosis: 1. Hypotension, unspecified hypotension type. 2. Acute blood loss anemia 3. Leukocytosis, unspecified type 4. Elevated troponin 5. AKI (Acute kidney injury) . Hospital Inpatient History & Physical dated 4/1/26 at 1:42 PM states in part .History of Present Illness: . Blood count revealed hemoglobin low at 6.2 with black stools which were heme (blood) positive. He also had elevated WBC and AKI.Patient has been on aspirin for many years. He is not on anything for stomach protection. He has had iron deficiency anemia in the past. In the emergency room the patient received IV (Intravenous) fluids, he was typed and crossed for 2 units (Blood transfusion) and is being admitted for ongoing care. R6 was discharged from the hospital on 4/6/26 and returned to the facility. On 5/28/26 at 9:19 AM, Surveyor interviewed DON B. Surveyor asked DON B what the expectation is for nurses when a resident has a change of condition, DON B stated that they have to start an e-interact change of condition form and notify the MD right away. Surveyor asked DON B if they would have expected the nurse caring for R6 on 4/1/26 to have completed an assessment, DON B stated yes. Surveyor asked DON B if they would expect the nurse to document their assessment and R6's vital signs, DON B stated yes. Surveyor asked DON B if they would have expected the nurse to notify the MD, DON B stated yes. Surveyor asked DON B what type of monitoring was put in place for R6's (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	aspirin use, DON B stated that usually everyone on aspirin gets put on anticoagulant med monitoring. DON B reported they could not find any anticoagulant monitoring in R6's orders. Surveyor asked DON B if monitoring should have been implemented, DON B stated yes. Example 2 The facility's weight assessment policy states, in part: *The nursing staff will measure resident weights on admission, the next 2 days, and weekly for 3 additional weeks thereafter. *Significant weight changes: .1 month--5% change is significant; greater than 5% is severe .3 months--7.5% weight change is significant; greater than 7.5% is severe .6 months--10% weight change is significant; greater than 10% is severe. *The nursing staff will notify the individual or responsible party and physician of any individual with an unintended significant weight change. *The physician and the interdisciplinary team will identify conditions and medications that may be causing weight change. For example: .Fluid imbalance and/or edema . R3 was admitted to the facility from the hospital on 4/7/26 and has diagnoses that include hypertensive (high blood pressure) heart disease with heart failure and chronic diastolic heart failure. Upon admission, R3's weight was recorded as 142 lbs (pounds). R3's hospital discharge orders state, in part, .Notify physician if patient's weight increases or decreases by 3 lbs in one day or 3 lbs in one week. R3 experienced a change in condition on 4/9/26 and was sent back to the hospital. The facility did not have any other weights than her admission weight on 4/7/26. It should be noted that R3 was hospitalized from [DATE] through 4/28/26. There is no indication or documentation for R3's weight at the hospital. R3's next weight at the facility on 4/29/26, upon re-admission R3's weight was 121 lbs. Additional weights for R3: 5/18/26: 126 lbs 5/19/26: 153.5 lbs (this is a 27.5-pound weight gain) 5/20/26: 153 lbs 5/21/26 151.5 lbs 5/22/26: 153.5 lbs (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility initiated a change of condition on 5/21/26, which states, .change in condition were Edema (new or worsening) .Weight gain related to increased fluid and edema throughout whole body. Pitting 2-3+ edema to legs. No shortness of breath but she does report a non-productive cough. There is no evidence or documentation that R3's physician was aware of this weight change before 5/21/26. R3 did not require hospitalization. On 5/28/2026 at 9:49 AM DON B (Director of Nursing) stated to Surveyor that R3 should have been weighed daily upon admission in accordance with the original hospital discharge orders. When asked about R3's 27.5 lb weight gain in one day, DON B stated she would expect the doctor to be notified right away, not wait for 2 days.

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F 0887 Level of Harm - Actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **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 medical record included documentation that indicates the resident or resident representative was provided education regarding the benefits and potential side effects of the COVID-19 vaccine, and that the resident (or representative) either accepted, received or declined the COVID-19 vaccine for 2 of 6 residents (R10 and R7) reviewed for COVID-19 vaccinations. R10 was not vaccinated for COVID-19 and became infected with COVID-19 that resulted in a hospitalization. The facility did not have documentation stating that the vaccination was offered, declined/consented to, or that the resident and or POA (Power of Attorney) was provided education on the vaccine. R7 was not vaccinated for COVID-19. The facility did not have documentation stating that the vaccination was offered, declined/consented to, or that the resident and or POA (Power of Attorney) was provided education on the vaccine. This is evidenced by:The facility's policy titled COVID-19 Vaccination last revised on 1/16/26 states in part .14. The facility will educate and offer the COVID-19 to residents.16. A copy of the Vaccine Information Statement (VIS) will be given to all staff, residents or resident representatives prior to administration and in conjunction with education as noted above.19. Residents or resident representatives retain the right to accept, refuse or change their decision about COVID-19 immunization. If refused, the residents will adhere to the protocols set forth by specific facility policy.21. The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or; c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or declination. a. Complete a risk vs benefit UDA (User-Defined Assessment) for resident declinations.The CDC's (Centers for Disease Control) article titled Symptoms of COVID-10 dated 3/10/25 states in part .Signs and Symptoms: The following list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. Possible symptoms include: Fever or chills, Cough, Shortness of breath or difficulty breathing, Sore throat, Congestion or runny nose, New loss of taste or smell, Fatigue, Muscle or body aches, Headache, Nausea or vomiting, Diarrhea. When to seek emergency help: Look for emergency warning signs* for COVID 19: Trouble breathing, Persistent pain or pressure in the chest, New confusion, Inability to wake or stay awake, Depending on skin tone, lips, nail beds and skin may appear pale, gray, or blue. Symptoms of COVID-19 | COVID-19 | CDC Example 1R10 was admitted to the facility on [DATE] with diagnoses that include dementia, anxiety disorder, depression, and a wedge compression fracture of the first lumbar vertebra (occurs when the anterior (front) portion of the L1 vertebral body collapses under compressive force, creating a wedge-shaped deformity).R10's most recent MDS (Minimum Data Set) dated 4/10/26 states that R10 has a BIMS (Brief Interview of Mental Status) of 2 out of 15, indicating that R10 has severe cognitive impairment. R10 has an APOA (Activated Power of Attorney).It is important to note that the facility did not have any documentation indicating that R10 and their APOA was offered, declined, consented to, or was provided education regarding the COVID-19 vaccine.Nurses' notes state the following:On 2/24/26 at 5:45 PM: Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Fever, Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts) Seems different than usual. At the time of evaluation resident/patient vital signs, weight, and blood sugar were: Blood Pressure: 115/72.Pulse: 95.RR (Respiratory Rate): 16.Temp (Temperature): 100.1.Pulse Oximetry (oxygen level) 93% .Room air.Outcomes of Physical Assessment: Mental status: altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse), Functional Status Evaluation: General weakness, Decreased mobility. Abdominal/GI status Evaluation: Decreased (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Few	appetite/fluid intake.Nursing observations, evaluation, and recommendations are: skin color abnormal, lung sounds clear, drowsy but easily aroused, no difficulty swallowing, weakness and fever present. Primary Care Feedback: A.recommended labs and cont. (continue) to monitor. B. New testing orders: Blood tests, Urinalysis or culture C. New Interventions orders: Increase oral fluids.On 2/25/26 at 6:30 PM: [R10's APOA name], approached this writer and voiced concern about [R10's Name] refusing to feed herself supper, lack of appetite, generalized weakness and occasional dry cough since lunchtime. This writer went into the room and evaluated resident at 5:30 PM. Resident color pale, slight tremors to hands, drowsy but brisk appropriate response to questions. No c/o (complaints of) pain or discomfort. Elevated temp of 100.1 forehead non-contact. Lung sounds clear. Resident took PRN (as needed) APAP (acetaminophen) administered with HS (bedtime) medications at that time spouse president in room.RN (Registered Nurse) on-call updated on status change at 5:40 PM, MD (Medical Doctor) on-call [MD's Name] returned call to facility at approximately 6:10 PM; provided update and orders for labs obtained.On 2/24/26 at 8:30 PM: CNA (Certified Nursing Assistant) approached this writer at approximately 7:30 PM with update that [R10's Name] was ?gurgling upon entry of room resident was audibly gurling [sic] and immediately rolled onto her left side and HOB (Head of Bed) elevated, resident expectorated (coughed up) moderate amount of white frothy sputum. Resident O2 sats 78% on room air with a pulse of 111. Supplemental O2 (oxygen) administered. RN on call contacted at 7:40 PM and given update. RN in agreement with this writers request to sent [sic] to ER (Emergency Room) for eval and treat for tachycardia and hypoxia.It is important to note that the facility did not perform COVID-19 testing despite R10's symptoms.ED (Emergency Department) notes dated 2/24/26 state in part Chief Complaint: Breathing Problem. History of present illness: [R10's Name] .presents with hypoxia (low levels of oxygen in your body tissues. It causes symptoms like confusion, restlessness, difficulty breathing, rapid heart rate and bluish skin) and altered mental status. History and exam is limited due to the patient's baseline dementia.Reportedly throughout the day today she had worsening alertness and a cough. She was coughing up some frothy sputum at 1 point. Started on oxygen after sats were noted to be in the 70s.Physical Exam: ED Triage vitals (2/24/26 at 8:32 PM): Pulse 108, Resp 20, BP 122/59, Temp 99.5, SpO2 89% .Medical Decision Making, ED Course & Medical Complexity: [R10's Name] is a [R10's age] female with a history of dementia, nursing home resident who presents with worsening alertness and acute respiratory failure with a cough. She was noted to be febrile prior to arrival here but was given Tylenol. Pulse is also tachycardic. Sats in the 80s on room air. Resolved with nasal cannula. Mildly increased work of breathing but no distress. IV (Intravenous) placed and blood work sent. Given the abnormal breath sounds fever and respiratory failure with apparently a productive cough reported prior to arrival I did empirically (by means of observation or experience rather than theory or pure logic) treat for bacterial pneumonia with Septra and azithromycin (antibiotics). Also started on fluids given the tachycardia (fast heart rate).Swab returns positive for COVID. This is likely the underlying cause of the patient's symptoms. Given the acute Evoxac respiratory failure I did give her 6mg (milligrams) of IV dexamethasone (steroid).Family Medicine admission H&P (History and Physical) dated 2/25/26 states in part .In the ED, pH (a measure of a fluid's acidity or alkalinity, determined by its hydrogen ion concentration) was 7.420 demonstrating respiratory alkalosis. BMP (Basic Metabolic Panel) was non revealing, BUN (measures the amount of urea nitrogen in your blood) 22, GFR (reflects how efficiently your kidneys filter blood through tiny structures called glomeruli, which remove waste and excess fluids) 54 otherwise normal. Fourplex showed COVID infection. EKG (measures the electrical waves in your heart) showed sinus tachycardia with a rate on 109.CXR (chest x-ray) showed emphysema with left basilar opacity felt possible to represent pneumonia, atelectasis or aspiration.Physical Exam: BP (!) 182/96.Pulse (!) 124 Temp 99.4.Resp (!) 32.SpO2 92% .Respiratory: increased work of breathing with O2 in place (patient had witnessed aspiration prior to exam). Scattered rhonchi (continuous low-pitched, rattling lung sounds that often resemble snoring) and gurgling. Assessment/ Plan: .hypoxia: COVID positive. CXR on admission not impressive for aspiration, however patient had (continued on next page)

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F 0887 Level of Harm - Actual harm Residents Affected - Few	witnessed aspiration event this am after Tylenol for fever. Work of breathing increased as did O2 needs. Patient less interactive, not following commands well after event. Given witnessed aspiration will as ceftriaxone and metronidazole.continue dexamethasone 6 mg daily, continue remdesivir, respiratory therapy per protocol.FEN (Fluids, Electrolytes, Nutrition): IVFs (IV fluids): 75ml/h (milliliters/hour) Electrolytes: trend, Diet: NPO.R10 remained in the hospital until 3/2/26 and returned to the facility.On 5/27/26 at 3:03 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R10 was offered that COVID-19 vaccination, DON B stated that they believed that R10 wanted one. Surveyor asked DON B what the process is for new admissions and vaccinations, DON B stated that they review the resident's record and H&P and the ADON (Assistant Director of Nursing) is in charge of offering immunizations. Surveyor requested documentation of R10 receiving or declining the vaccination.On 5/28/26 at 9:15 AM, Surveyor interviewed DON B. Surveyor asked DON B if they were able to find documentation of R10 declination of the COVID-19 vaccine, DON B stated they were unable to find documentation. Surveyor asked DON B if there should have been signed declinations, DON B stated yes.The facility failed to offer, administer, or ensure declinations were provided to residents regarding the COVID-19 vaccine, resulting in a 6-night hospitalization for R10. Example 2R7 was admitted to the facility on [DATE] with diagnoses that include frontotemporal neurocognitive disorder, dementia with severe agitation, mood disorder, and violent behavior.R7's most recent MDS dated [DATE] states that R7 has a BIMS of 0 out of 15, indicating that R7 has severe cognitive impairment.On 3/18/26, R7 has a declination signed for the PCV20 (pneumococcal conjugate vaccine). R7 does not have a declination for the COVID-19 vaccine.On 5/27/26 at 3:03 PM, Surveyor interviewed DON B (Director of Nursing) Surveyor asked DON B what the process is for new admissions and vaccinations, DON B stated that they review the resident's record and H&P and the ADON (Assistant Director of Nursing) is in charge of offering immunizations. Surveyor asked DON B if there was any documentation indicating that R7 had received or declined the COVID-19 vaccine, DON B stated that they would have to look.Surveyor requested documentation of R7 receiving or declining the vaccination.On 5/28/26 at 9:15 AM, Surveyor interviewed DON B. Surveyor asked DON B if they were able to find documentation of R7's declination of the COVID-19 vaccine, DON B stated they were unable to find documentation. Surveyor asked DON B if there should have been signed declinations, DON B stated yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525354	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineral Point Health Services	109 N Iowa St Mineral Point, WI 53565

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 12 sampled Residents (R6).R6 has facial hair that is approximately 1/4- 1/2 long and fingernails that are long with a black substance underneath them.Evidenced by:The facility's policy titled Activities of Daily Living (ADLS) last reviewed on 7/26/22 states in part .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care.3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.R6 was admitted to the facility on [DATE] with diagnoses that include heart disease, type 2 diabetes mellitus, squamous cell carcinoma of skin and neck (skin cancer), and long-term aspirin use.R6's most recent MDS (Minimum Data Set) dated 4/24/26 states that R6 has a BIMS (Brief Interview of Mental Status) of 6 out of 15, indicating that R6 is severely cognitively impaired. R6's MDS also indicates that they are dependent on staff for all ADLs.R6's care plan 2/16/26 states in part .Focus: ADL self-care deficit related to: physical limitations.Interventions/Tasks: .Check nail length and clean on bath day and as necessary. Report any changes to the nurse. Licensed nurse to trim d/t (due to) DM dx (Diabetes Mellitus diagnosis) . Bathing/Showering: Assist of 1, Prefers SHOWER Thursday Day shift. Prefers shower around 6 am if possible.Personal hygiene: Assist of 1.On 5/26/26 at 12:25 PM, Surveyor interviewed R6. Surveyor noted that R6 has facial hair that is approximately 1/4- 1/2 long and fingernails that are long (past the tip of the finger) with a black substance underneath them. Surveyor asked R6 if they prefer to have facial hair or to be clean shaven, R6 stated that they prefer to be clean shaven and that whiskers aren't for them.On 5/27/26 at 12:14 PM, Surveyor observed R6. Surveyor noted that R6 continues to be unshaven, and their fingernails remain long with a black substance underneath them.On 5/27/26 at 12:21 PM, Surveyor interviewed CNA J (Certified Nursing Assistant) . Surveyor asked CNA J if they were familiar with R6, CNA J stated yes. Surveyor asked CNA J how often residents get shaved, CNA J stated every day. Surveyor asked if residents can be shaved on any shift, CNA J stated yes. Surveyor asked CNA J if they noticed that R6 hadn't been shaved, CNA J stated yes. Surveyor asked how often nail care should be provided, CNA J stated as needed. Surveyor asked CNA J if they noticed that R6's nails are dirty, CNA J stated that they don't know how to get them cleaned and that they have asked the other shift to soak them with R6's shower.On 5/27/26 at 3:27 PM, Surveyor interviewed R6. Surveyor asked R6 if they like their fingernails shorter, R6 stated yes, and they need cleaning. Surveyor notes that R6 remains unshaven.On 5/28/26 at 8:23 AM, Surveyor observed R6. Surveyor notes that R6 remains unshaven and fingernails remain long and dirty.On 5/28/26 at 8:37 AM, Surveyor interviewed LPN K (Licensed Practical Nurse). Surveyor asked LPN K how the nurses know what residents require nail care by the nurses, LPN K stated that all diabetic residents do. Surveyor asked LPN K when nail care is provided, LPN K stated that it is provided on shower day, the CNAs clean them, and the clipping is done by the nurses. Surveyor asked how the nail care is documented, LPN K stated that it is not documented. Surveyor asked LPN K if there is documentation for the last time R6's nails have been clipped and cleaned, LPN K stated no. Surveyor and LPN K observed R6's nails together. Surveyor asked LPN K if R6's nails need to be clipped and cleaned, LPN K stated yes. Surveyor asked LPN K how often residents should be shaved, LPN K stated that if there is facial hair, they should be shaved.On 5/28/26 at 9:26 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how often they would expect residents should be shaved, DON B stated per resident preference and daily if they need it. Surveyor asked DON B if R6 refuses cares, should that be documented, DON B stated that they would look. Surveyor asked DON B how the nurses know which residents require them to perform nail care, DON B stated that it is in the care plan, and the CNAs will (continued on next page)

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	525354	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineral Point Health Services	109 N Iowa St Mineral Point, WI 53565

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	let the nurses know when they need taken care of. Surveyor asked DON B where nail care is documented, DON B stated that they don't think it is documented.

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	525354	A. Building B. Wing	05/28/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not offer each resident influenza immunization, and the resident's medical record does not include documentation the resident either received, refused, or was educated on the risks and benefits of the influenza immunization for 1 of 5 residents (R7) reviewed for immunizations. R7 did not receive the influenza vaccine. The facility did not have documentation stating that the vaccination was offered, declined/consented to, or that the resident or their Guardian was provided education on the influenza vaccine. Evidenced by:The facility's policy titled Influenza Vaccination last reviewed on 9/5/25 states in part .2. Influenza vaccinations will be routinely offered annually when it becomes available to the facility, unless such immunization is medically contraindicated, the individual has already been immunized during the time period or refuses to receive the vaccine.9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of the immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. Consider use of the Risk vs. Benefit UDA (User- Directed Assessment) in the electronic medical record as means to capture the resident's choice to not receive the influenza vaccination. R7 was admitted to the facility on [DATE] with diagnoses that include frontotemporal neurocognitive disorder (progressive brain disease characterized by the degeneration of the frontal and temporal lobes), dementia with severe agitation, mood disorder, and violent behavior.R7's most recent MDS dated [DATE] states that R7 has a BIMS of 0 out of 15, indicating that R7 has severe cognitive impairment. R7 has a Guardian.On 3/18/26, R7 has a declination signed for the PCV20 (pneumococcal conjugate vaccine). R7 does not have a declination for the Influenza vaccine.On 5/27/26 at 3:03 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for new admissions and vaccinations, DON B stated that they review the resident's record and H&P (History and Physical) and the ADON (Assistant Director of Nursing) is in charge of offering immunizations. Surveyor asked DON B if there was any documentation indicating that R7 had received or declined the influenza vaccine, DON B stated that they would have to look.Surveyor requested documentation of R7 receiving or declining the vaccination.On 5/28/26 at 9:15 AM, Surveyor interviewed DON B. Surveyor asked DON B if they were able to find documentation of R7's declination of the influenza vaccine, DON B stated they were unable to find documentation. Surveyor asked DON B if there should have been signed declinations, DON B stated yes.