STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525411	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowdale Health Services	1610 Hoover St New Holstein, WI 53061

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmision of communicable disease and infection when 6 nursing staff (Licensed Practical Nurse (LPN)-G, LPN-L, Registered Nurse (RN)-I, Certified Nursing Assistant (CNA)-H, CNA-J, and CNA-K) did not complete required COVID-19 testing during a COVID-19 outbreak. This practice had the potential to affect all 25 residents residing in the facility.The facility had a COVID-19 outbreak that started on 1/14/26 and was still active on 2/11/26. LPN-G, LPN-L, RN-I, CNA-H, CNA-J, and CNA-K did not test for COVID-19 every other day and document the results in accordance with the facility's policy prior to working their scheduled shifts.Findings include:The facility's COVID-19 Prevention, Response and Reporting policy, revised 12/8/25, indicates: It is the policy of this facility to ensure appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections .The facility will perform viral testing for COVID-19 per national standards such as the Centers for Disease Prevention and Control (CDC) recommendations .Infection Control Guidance located at https://www.cdc.gov indicates the CDC recommendations for employee COVID-19 testing during a facility outbreak include: 1) Routine testing: Facilities should implement routine testing for healthcare personnel who have had a higher risk of exposure, regardless of vaccination status, to ensure safety and prevent transmission.On 2/10/26 at 10:45 AM, Director of Nursing (DON)-B provided Surveyor with a Critical Event Analysis and Action Plan Worksheet. DON-B indicated the facility discovered areas of improvement needed on 1/30/26 and was working toward correcting them. DON-B indicated part of the action plan included staff not following the facility's policy for COVID-19 testing. The Critical Event Analysis and Action Plan indicated the DON/designee was re-educating staff on the facility's COVID-19 prevention, response, and reporting policy and testing requirements. Surveyor noted the training log/sign in sheet for Response and Reporting and COVID-19 testing, dated 2/4/26, did not include CNA-H's signature.On 2/10/26 at 1:55 PM, Surveyor interviewed DON-B who indicated the faciltiy's procedure is for staff to enter the building by the timeclock, complete a COVID-19 test, and document their name, date, time, and test result prior to clocking in for their scheduled shift. Surveyor requested staff COVID-19 tests for 1/30/26 through 2/10/26. On 2/11/26 at 11:33 AM, DON-B provided documentation of staff COVID-19 tests. DON-B stated the facility's policy during a COVID-19 outbreak requires staff to complete a COVID-19 test every other day prior to clocking in for their shift and to document the results on a log.On 2/11/26, Surveyor reviewed nursing staff timecard punches for 1/30/26 through 2/11/26 and cross-referenced COVID-19 testing provided by DON-B. Surveyor noted the following nursing staff did not complete COVID-19 testing during the following timeframes in which they worked:~ LPN-G did not complete COVID-19 tests from 2/4/26 through 2/8/26. ~ CNA-H did not complete COVID-19 tests from 2/4/26 through 2/10/26.~ RN-I did not complete a COVID-19 test on 2/4/26. (RN-I last tested on [DATE]).~ CNA-J did not complete COVID-19 tests from 2/4/26 through 2/10/26.~ CNA-K did not complete a COVID-19 test on 2/6/26.~ LPN-L did not complete COVID-19 tests on 2/7/26 or 2/8/26.On 2/11/26 at 1:10 PM, Surveyor interviewed DON-B and Nursing Home Administrator (NHA)-A who were not aware that staff did not complete COVID-19 testing per (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy during the facility's COVID-19 outbreak. DON-B indicated administration was working on a program to complete testing audits since the facility did not have a system to ensure staff completed the testing. DON-B and NHA-A were also not aware that CNA-H did not complete COVID-19 testing training on 2/4/26.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, resident, and resident representative interview and record review, the facility did not notify a Power of Attorney (POA) or family representative of a change in condition for 3 residents (R) (R33, R20, and R6) of 6 sampled residents.R33 passed away on 1/27/26. R33's family was not notified of R33's passing in a timely manner.R20 was diagnosed with COVID-19 on 2/2/26 and was moved to a private room for isolation protocol. R20's POA was not notified of the diagnosis or room change until 2/4/26.R6 was diagnosed with COVID-19 on 1/29/26. R6's POA was not notified of the diagnosis until 2/5/26. Findings include: The facility's Change in Condition of the Resident policy, revised 9/20/22, indicates: The facility should immediately inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident's representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications), or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .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 .Notify the resident's family/responsible party as applicable and in accordance with the resident's wishes. 1.On 2/10/26, Surveyor reviewed R33's medical record. R33 had diagnoses including Parkinson's disease, prostate cancer, chronic kidney disease stage 3, and COVID-19 (dated 1/19/26). R33's Minimum Data Set (MDS) assessment, dated 1/21/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R33 had intact cognition. R33 was R33's own decision maker. R33 passed away on 1/27/26. R33's medical record did not indicate R33's family was notified when R33 passed away. R33's medical record contained two family emergency contacts to be notified of a change in condition. On 2/10/26, Surveyor reviewed the facility's grievance file and noted a grievance submitted by R33's family representative on 1/27/26 that indicated R33's family was not notified when R33 passed away. The corrective action taken indicated education was provided to Licensed Practical Nurse (LPN)-N and R33's family received an apology. The grievance indicated LPN-N received education on 1/29/26 regarding calling families, physicians, and managed care organizations to update on residents' conditions. 2. On 2/10/26, Surveyor reviewed R20's medical record. R20 had a diagnosis of COVID-19 (dated 2/2/26). R20's MDS assessment, dated 2/3/26, had a BIMS score of 3 out of 15 which indicated R20 had severely impaired cognition. R20 had an activated POA. A progress note, dated 2/4/26, indicated R20's POA was not notified on 2/2/26 of R20's room change or COVID-19 diagnosis. A grievance form was completed for the concerns. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/10/26, Surveyor reviewed the facility's grievance file and noted a grievance submitted by R20's POA on 2/4/26 that indicated R20's POA was not notified of R20's COVID-19 diagnosis. The grievance indicated nurses were educated on notification of a change in condition and R20's POA received an apology. 3. From 2/9/26 to 2/11/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including diabetes and stroke. R6's MDS assessment, dated 12/2/25, had a BIMS score of 15 out of 15 which indicated R6 had intact cognition. R6 did not have an activated POA but requested R6's designated POA be notified of any changes. A nursing note, dated 1/29/26, indicated R6's physician was notified of R6's positive COVID-19 test. R6's medical record did not indicate R6's representative (Power of Attorney (POA)-R) was notified of the positive test. On 2/9/26 at 11:01 AM, Surveyor interviewed POA-R who expressed concern about delayed notification of R6's COVID-19 diagnosis. POA-R stated POA-R was notified immediately by R6 but was not notified by the facility until 5-7 days later. On 2/10/26 at 12:54 PM, Surveyor interviewed R6 who was not sure if R6 notified POA-R and was not sure when the facility notified POA-R. On 2/10/26 at 10:45 AM and on 2/11/26 at 9:11 AM, Surveyor interviewed Director of Nursing (DON)-B who provided a Critical Event Analysis and Action Plan Worksheet and stated the facility discovered areas that needed improvement on 1/30/26 and were working to correct them. DON-B stated the action plan included notification of a resident's representative/POA regarding a change in condition. The action plan indicated the interim DON noted on 1/30/26 that families were not updated during the facility's COVID-19 outbreak. All families had since been called and COVID-19 positive residents were reviewed to ensure the correct precautions, notifications, care plans, orders, and documentation were in place. The action plan indicated the DON/designee would re-educate nurses on the facility's Change in Condition policy and audit any new residents diagnosed with COVID-19 until the outbreak was over. A training log/sign in sheet for change in condition/notification education, dated 2/5/26, contained the signatures of six nurses. Surveyor noted LPN-N, LPN-L, and Registered Nurse (RN)-M were not on the sheet. Surveyor reviewed the facility's COVID-19 outbreak timeline which indicated the outbreak started on 1/14/26. The timeline indicated the following: ~ On 1/19/26, R33 tested positive for COVID-19. On 1/27/26 R33 passed away. ~ On 2/2/26, R20 tested positive for COVID-19. ~ On 1/29/26, R6 tested positive for COVID-19. On 2/11/26, Surveyor requested and reviewed nursing staff timecard punches for 1/30/26 through 2/9/26 and noting the following: ~ LPN-N worked on 2/6/26, 2/7/26, and 2/8/26 but did not receive notification education. ~ LPN-L worked on 2/4/26, 2/5/26, 2/6/26, 2/7/26, and 2/8/26 but did not receive notification education. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ RN-M worked on 2/5/26 but did not receive notification education. DON-B indicated notification documentation was located in the facility's infection control binder. DON-B stated the facility's notification process depends on if the resident is their own decision maker and wants the facility to notify their famiy. DON-B stated if a resident has a Guardian or an activated POA, the facility notifies the resident's representative within 24 hours. DON-B noticed nurses were not completing notifications timely and started an improvement plan. DON-B stated at the time R6 tested positive for COVID-19, the facility was operating as if R6's POA was activated and should have notified R6's representative within 24 hours. On 2/11/26 at 1:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B. NHA-A indicated the grievance filed by R20's POA started the review of residents' records to ensure notifications were made to all family members. NHA-A and DON-B indicated they were not aware of notification concerns prior to that date and stated the action plan to correct the issue was initiated due to the grievance. NHA-A stated when notification for R33's death occurred on 1/27/26, NHA-A did not see notification as a widespread issue and all nurses were not trained at that time. NHA-A verified notification for R6's COVID-19 positive test on 1/29/26 was not relayed timely to R6's POA. NHA-A and DON-B were not aware that all nurses were not trained on 2/5/26 and confirmed the facility's action plan had not been fully completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Minimum Data Set (MDS) assessment was completed accurately for 2 residents (R) (R8 and R4) of 5 sampled residents.R8's MDS assessment, dated 1/27/26, did not indicate R8 had a serious mental illness.R4's MDS assessment, dated 11/13/25, did not indicate R4 had a serious mental illness. Findings include: The facility's Resident Assessment-Coordination with Pre-admission Screening and Resident Review (PASRR) Program, revised 11/10/25, indicates: All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the state's Medicaid rules for screening .a. PASRR Level I - intial pre-screening that is completed prior to admission: 1. Negative Level I Screen - permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later .12. Positive Level I Screen - necessitates a PASSR Level II evaluation prior to admission. 1.From 2/9/26 to 2/11/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including bipolar mood disorder and anxiety. R8's Minimum Data Set (MDS) assessment, dated 1/27/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 had intact cognition. R8 made R8's own medical decisions. R8's medical record indicated R8 had a diagnosis of bipolar mood disorder. R8's MDS assessment at Section A1500, dated 1/27/26, indicated R8 did not have a serious mental illness. On 2/11/26 at 11:37 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B and reviewed R8's MDS assessment. NHA-A and DON-B verified R8 had a mental illness that should have been reflected in Section A1500 on the MDS assessment. 2. From 2/9/26 to 2/11/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including bipolar disorder, anxiety, and major depression. R4's MDS assessment, dated 11/13/25, had a BIMS score of 15 out of 15 which indicated R4 had intact cognition. R4 made R4's own healthcare decisions. R4's medical record indicated R4 had diagnoses including bipolar disorder, anxiety, and major depression. R4's MDS assessment, dated 11/13/25, indicated R4 did not have a serious mental illness. On 2/10/26 at 12:13 PM, Surveyor observed [NAME] President of Success (VPS)-C and Social Worker (SW)-E review Section A1500 of R4's 11/13/25 MDS assessment. VPS-C and SW-E confirmed the MDS assessment was incorrect. SW-E confirmed SW-E completed Section A1500 and should have documented Section A1500 as not assessed.

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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 staff interview and record review, the facility did not ensure 2 residents (R) (R8 and R4) of 5 sampled residents suspected of having a mental illness and/or intellectual/developmental disability were screened through the Pre-admission Screening and Resident Review (PASRR) Level II process to determine if nursing home placement was appropriate and if specialized services were required.The facility did not ensure completion of PASRR Level II Screens for R8 and R4.Findings include: The facility's Resident Assessment-Coordination and PASRR Program, revised 11/10/25, indicates: This facility coordinates assessments with the PASRR program under Medicaid to ensure individuals with a mental disorder .receive care and services in the most integrated setting appropriate to their needs .a. ii. Positive Level I Screen - necessitates a PASRR Level II evaluation prior to admission. b. PASRR Level II Screen - a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual who has a mental disorder .determines the appropriate setting for the individual and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder .who the state mental health .authority has determined as appropriate for admission. 3. A record of the pre-screening shall be maintained in the resident's medical record. 1. From 2/9/26 to 2/11/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including bipolar mood disorder and anxiety. R8's Minimum Data Set (MDS) assessment, dated 1/27/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R8 had intact cognition. R8's MDS assessment at Section A1500 indicated R8 did not have a serious mental illlness. R8 made R8's own medical decisions. On 2/10/26, Surveyor reviewed R8's PASRR Level I Screen which indicated R8 did not have a mental illness despite the fact R8 had a diagnosis of bipolar mood disorder. On 2/11/26 at 11:37 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B and reviewed R8's PASSR Level I Screen. NHA-A and DON-B verified R8 had a mental illness that should have been documented on R8's PASRR Level I Screen. NHA-A and DON-B verified R8 should have had a PASRR Level II Screen completed and submitted for review. 2. From 2/9/26 to 2/11/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including bipolar disorder, anxiety, and major depression. R4's MDS assessment, dated 11/13/25, had a BIMS score of 15 out of 15 which indicated R4 had intact cogniton. R4's MDS assessment indicated at Section A1500 that R4 did not have a serious mental illness. R4 made R4's own healthcare decisions. R4's medical record did not contain a PASRR Level II Screen or county exemption paperwork. On 2/9/26 and on 2/10/26 at 8:39 AM, Surveyor requested R4's PASRR Level II Screen from NHA-A. On 2/10/26 at 12:13 PM, Surveyor interviewed SW-E who confirmed R4's PASRR Level II Screen was completed on 2/9/26 after Surveyor requested the form. SW-E indicated R4's PASRR Level I Screen should have indicated R4 had a serious mental illness. SW-E verified the facility did not have a copy of R4's county exemption paperwork.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a comprehensive resident-centered dementia care plan was implemented for 1 resident (R) (R17) of 3 sampled residents.R17 had diagnoses of dementia and Alzheimer's disease. R17's comprehensive care plan did not contain dementia disease-related goals or interventions for care.Findings include:The facility's Comprehensive Care Plan policy, revised 9/23/22, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .On 2/11/26, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had diagnoses including dementia and Alzheimer's disease. R17's Minimum Data Set (MDS) assessment, dated 12/2/25, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R17 had moderate cognitive impairment. The MDS assessment indicated R17's active diagnoses included dementia and Alzheimer's disease. R17 was responsible for R17's healthcare decisions.A hospital Discharge summary, dated [DATE], indicated R17 had baseline cognitive impairment which contributed to difficulty following cues during therapy and impaired safety awareness during transfers and activities of daily living (ADLs).On 2/11/26, Surveyor reviewed R17's plan of care which did not contain dementia goals or interventions for care. R17's Kardex (an abbreviated care plan used by nursing staff) also did not contain interventions related to dementia.On 2/11/26 at 1:02 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who stated R17 had behaviors when R17 was admitted to the facility; however, CNA-F had not observed any recent behaviors. CNA-F reviewed R17's care plan and Kardex and confirmed R17's care plan did not address dementia.On 2/11/26 at 1:24 PM, Surveyor interviewed Registered Nurse (RN)-D who confirmed R17's care plan did not address dementia. RN-D stated if R17 had dementia-related concerns, interventions would be added to R17's care plan. RN-D indicated R17 was able to communicate R17's needs at that time and stated a baseline care plan is developed upon admission.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R5) of 1 sampled received the necessary care and services to prevent the development of pressure injuries and/or promote healing.R5 was admitted with stage 3 pressure injury on the left buttock and had an order for a pressure reducing mattress to be set at 150 pounds. During observations on 2/9/26, 2/10/26, and 2/11/26, R5's pressure reducing mattress was set at 200 pounds.Findings include:Based on guidelines followed by major medical organizations and the Centers for Medicare & Medicaid Services (CMS) criteria, which inform clinical practice, pressure-reducing mattresses - Avoid Excessive Firmness: While preventing bottoming out is critical, setting the pressure too high makes the mattress too firm, reducing its ability to conform to the body and increasing rather than reducing interface pressure on bony prominences (e.g., tailbone, heels).From 2/9/26 to 2/11/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including left buttock ulcer, diabetes with chronic kidney disease, protein-calorie malnutrition, and metabolic encephalopathy. R5's Minimum Data Set (MDS) assessment, dated 1/26/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. The MDS assessment indicated R5 had a stage 3 pressure ulcer upon admission. R5 made R5's own medical decisions.R5's medical record indicated R5's left buttock pressure injury measured 3 centimeters (cm) (length) x 2.5 cm (width) x.1 cm (depth) on 12/23/25. On 2/9/26, R5's left buttock pressure injury measured 3 cm x 4 cm x 0.1 cm.R5's medical record contained an order for a pressure reducing mattress set at 150 pounds. R5's Medication Administration Record (MAR) indicated R5's pressure reducing mattress should be set at 150 pounds and documented every shift.On 2/9/26 at 11:19 AM and 2/10/26 at 1:53 PM, Surveyor observed R5 in a wheelchair with a pressure reducing cushion in R5's room. Surveyor noted R5's pressure reducing mattress was set at 200 pounds.On 2/11/26 at 7:45 AM, Surveyor observed R5 in a bed in R5's room that did not have a pressure reducing mattress. Surveyor verified with Director of Nursing (DON)-B that R5 was not in the correct bed. DON-B indicated night shift staff reported that R5 self-transferred into the wrong bed and refused to get out. Surveyor attempted to interview R5 who indicated R5 sleeps wherever its available. Surveyor noted R5's pressure reducing mattress was on and set at 200 pounds. A progress note, dated 2/11/26 at 3:30 AM, indicated R5 refused to be in bed with the pressure reducing mattress because the mattress was deflated last week but was fixed by maintenance staff.On 2/11/26 at 12:17 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-O who stated R5 often self-transfers into a bed of choice. CNA-O stated only nurses check and adjust air mattress settings.On 2/11/26 at 12:32 PM, Surveyor interviewed Registered Nurse (RN)-P who verified R5's air mattress was set at 200 pounds. RN-P reviewed R5's MAR and verified the mattress should be set at 150 pounds per R5's order. RN-P stated the mattress is locked when it is set and must be unlocked to change the setting. Surveyor observed RN-P unlock the air mattress and change the setting to 150 pounds.On 2/11/26 at 12:38 PM, Surveyor interviewed DON-B who verified R5's air mattress was set at 200 pounds and should have been set at 150 pounds.