STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525445	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Health and Rehab	825 Western Ave. Columbus, WI 53925

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect 39 of 39 residents residing in the facility on 3 of 3 units. R12, R18, R7, R30, R39, R2, R42, and R17 voiced concerns to staff related to receiving hot foods at a cold and undesirable temperature. These residents reside on 3 of 3 units. Surveyor conducted a test tray, and the result was not palatable. R10, R23. R49 and R1 voiced concerns regarding cold food. Evidenced by: The facility did not provide a policy and procedure for food temperatures. Example 1 On 05/19/26 at 12:26 PM during initial screening, R10 stated the food is terrible. Everything is cold. I eat in my room and by the time I get it, it is cold. I occasionally go to the dining room, but it is still cold. Example 2 On 05/19/26 at 8:55 AM, during initial screening, R23 stated that the food was terrible. It is always cold. I guess they would heat it up but I shouldn't have to ask. You get tired of eating cold food. Example 3 On 05/19/26 at 10:03 AM during initial screening R49 stated that the food is not good. It is usually cold. The oatmeal is never warm, let alone hot. On 05/21/2026 at 8:02 AM, R49 indicated to surveyor that the oatmeal was cold yesterday. R49 went to the dining room yesterday for dinner and the biscuits were soggy. Example 4: On 5/19/26 at 10:04 AM, Surveyor interviewed R1 during initial screening. R1 indicated that food is (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cold when receiving meal trays in room. Example 5 On 5/19/26 at 3:50 PM, during resident council meeting R12, R18, R7, R30, and R39 indicated they receive hot foods at a cold and undesirable temperature. R12, R18, R7, R30, and R39 also indicated they have voiced concerns many times to staff regarding their food being served at undesirable temperatures. On 5/20/26 at 9:09 AM, CNA P (Certified Nursing Assistant), CNA G, and CNA O indicated R2, R7, R42, and R30 often complain about receiving their hot foods at a cold or undesirable temperature. On 5/20/26 9:04 AM Surveyor received a test tray and recorded the following temperatures and descriptions: biscuits and gravy- 98 degrees, cool to touch. scrambled eggs 96 degrees cool to touch . hot cereal 132 degrees. Surveyor noted the metal disc under the plate and the plate to be lukewarm to the touch. On 5/20/26 at 2:24 PM, AD S (Activity Director) indicated R7 complains almost daily that her hot meals are served at a cooler and undesirable temperature. On 5/21/26 at 12:14 PM, DM M (Dietary Manager) indicated 96 degrees, and 98 degrees are not desirable temperatures for hot food. DM M indicated he is aware there have been concerns related to cold food. DM M indicated staff were supposed to serve one hallway at a time, but yesterday they put all three hallways on one insulated cart and passed them out. DM M indicated the meals cool down fast because the cart door opens and closes for each tray to be passed. On 5/21/26 at 2:11 PM, NHA A (Nursing Home Administrator) indicated hot foods should be served hot and cold foods should be served cold. NHA A indicated the facility has a Project Improvement Plan for meal temperatures, but the kitchen staff failed to follow the plan and resorted back to old ways where they put all room trays in an insulated cart and took them all out at once. NHA A indicated the plan is to serve one hallway and pass those. Then return to the kitchen to serve up the next hallway and pass those. Then return for the third hallway's trays and pass. This was an effort to not have to have the trays in the insulated cart cooling while waiting to be passed.

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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 39 residents who reside in the facility.Surveyor observed 3 sprinklers and the surrounding ceiling to be covered in a layer of dust. The sprinklers are directly above food preparation area.Surveyor observed the facility's freezer to have frozen drips hanging from the ceiling and boxes that have ice buildup on and inside with food no longer sealed by the manufacturer.Surveyor observed [NAME] D serving food 2 days without donning a beard net.Surveyor observed 3 dented cans in circulation.Evidenced by:Example 1Facility policy, titled Sanitation, revised 10/22, includes: Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.On 5/20/26 at 9:44 AM Surveyor, [NAME] N and DM M (Dietary Manager) observed 3 sprinkler heads and the surrounding ceiling to be covered in a thin layer of dust. [NAME] N and DM M indicated they were unsure who was to be cleaning these. DM M indicated there is potential for the dust to dislodge and fall into food being prepared underneath them.On 5/21/26 at 2:11 PM NHA A (Nursing Home Administrator) indicated the Maintenance staff should be cleaning these areas regularly.Example 2On 5/19/26 at 8:41 AM during the initial tour of the facility's main kitchen, Surveyor observed frozen dripping in the walk-in freezer on the ceiling, on sprinkler heads, under the shelving, and on boxes of unsealed food. DM M opened the boxes of biscuit dough, vegetables, pork fritters, and beef patties revealing they were no longer sealed by the manufacturer. DM M indicated the dripping could get inside of the unsealed packaging contaminating the food.On 5/21/26 at 2:11 PM NHA A indicated there should be some kind of barrier to protect the boxes from the dripping condensation in the freezer unit.Example 3Facility policy, titled Preventing Foodborne illness- Employee Hygiene and Sanitary Practices, last revises 10/23, includes: Hairnets and/or chef's caps, and/or beard restraints must be worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens.On 5/19/26 at 8:41 AM Surveyor observed [NAME] D to have a full goatee and to be plating residents' food without donning a beard restraint.On 5/20/26 at 12:00 PM Surveyor observed [NAME] D to have a full goatee and to be plating resident food without donning a beard restraint.On 5/21/26 at 12:14 PM DM M indicated [NAME] D should have a beard net on to cover facial hair when working with or near food.On 5/21/26 at 2:11 PM NHA A indicated all hair must be covered while working in the food preparation area.Example 4Facility policy, titled Food Safety Requirements, revised 10/22, includes: Dented cans will be identified and removed from regular dry food storage. The dented cans should be placed in a specific labeled area of the storage room awaiting pick up from the appropriate vendor.On 5/19/26 at 8:41 AM during initial tour of the facility's kitchen, Surveyor observed 3 dented cans on the shelf in the dry storage unit. During an interview, DM M (Dietary Manager) indicated he would use the dented can if it was dented as long as it was not dented on the can's seam.On 5/21/26 at 2:11 PM NHA A (Nursing Home Administrator) indicated staff should not use dented cans at all.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure prompt resolution of all grievances for 3 of 3 sampled residents (R2, R7, R17) and 2 of 2 supplemental residents (R42, R30) reviewed for grievances. R2, R7, R42, R30, and R17 voiced concerns/grievances to staff. Staff did not follow the facility's grievance process. CNA P (Certified Nursing Assistant), CNA O, and CNA G indicated R2, R7, R42, and R30 voiced concerns related to being served hot food at a cool and undesirable temperature and they did not use the facility's grievance process to track, address, or look for trends throughout the facility. AD S (Activity Director) indicated R7 tells her almost daily that her hot foods are served cold and at an undesirable temperature. Evidenced by: Facility policy, titled Filing Grievances/Complaints, revised 11/2017, includes: Any resident, his or her representative, family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of property, etc without fear of threat or reprisal in any form. Grievances/Complaints may be submitted orally or in writing. Upon receipt of a grievance or complaint the Grievance Official will investigate the allegations and submit a written report of such findings to the Administrator within 5 working days of receiving the grievance and/or complaint. The Grievance Official will also give written grievance decision to the resident. The community will maintain 3 years of results of the Grievance Process. The log and results will be maintained for 3 years. The Grievance/Complaint log will be reviewed by the Quality Assurance and Assessment Committee at least quarterly. Example 1: On 5/19/26 at 3:50 PM, R30 indicated she does not go to staff with concerns anymore because they do not do anything about it. R30 indicated one of her concerns is that she gets served her hot food at a cool and undesirable temperature. On 5/19/26 at 3:50 PM R7 indicated she complains to staff almost daily that her hot food being served at a cool and undesirable temperature. On 5/20/26 at 9:09 AM, CNA P, CNA O, and CNA G indicated R2, R7, R42, and R30 often complain about receiving their hot foods at a cold or undesirable temperature. CNA P, CNA O, and CNA G indicated they did not fill out a grievance form when R2, R7, R42, and R30 complained of being served cold food. CNA G, CNA O, and CNA P indicated they did not report these concerns to the facility's Grievance Official. On 5/20/26 at 2:24 PM, AD S (Activity Director) indicated R7 complains almost daily that her hot meals are served at a cooler and undesirable temperature. AD S indicated she does not record this concern on a grievance form, but she should so the facility can see how often it is occurring and try to (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	get to the root of the concern. On 5/20/26 at 2:58 PM, NHA A (Nursing Home Administrator) indicated it is important that staff use the facility's grievance process to report grievances voiced by the residents to the facility can track and trend the grievances. NHA A indicated once a grievance is voiced the facility will investigate it and try to come up with a resolution that satisfies the person who voiced the concern. NHA A indicated a concern related to a resident's stay, the food, the care, or the environment is a grievance. On 5/21/26 at 12:14 PM DM M (Dietary Manager) indicated he is aware there have been resident concerns related to cold food and staff should be recording the concerns using the grievance forms so he can see which halls and which meals and how frequently the concerns are coming up. Example 2 R17 admitted to the facility on [DATE] and has diagnoses that include: cervical disc disorder with myelopathy, mid-cervical region (a progressive condition where a degenerated or herniated disc in the neck compresses the spinal cord, leading to loss of coordination, balance issues, and muscle weakness); Need for Assistance with personal care; muscle weakness; lack of coordination. R17's MDS (Minimum Data Set), dated 2/18/26, indicates a BIMS (Brief Interview for Mental Status) score of 15, indicating R17 is cognitively intact. On 5/19/26 at 10?32 AM, Surveyor interviewed R17 during initial screening. R17 stated that on 5/16/26 he/she had requested to use the bathroom at 11:45 AM. The nurse stated he/she would get someone. Two CNAs (Certified Nursing Assistant) came into the room separately while I was waiting, but didn't help me. Two other CNAs came in at 1:00 PM and assisted. R17 verbalized concern with needing to wait so long for assistance. R17 stated I told CNA K about the wait; he/she scolded the staff. R17 stated that the following day, one of the CNAs that didn't help me on Saturday, CNA L came to get me dressed. CNA L got me half dressed, then left without telling me where he/she was going and never came back. I waited over an hour for others to come and get me out of bed. Important to note: Surveyor reviewed facility grievance log. There was no grievance for R17 regarding concern of care. R17's Care Plan states, in part: Focus: R17 has an ADL (activities of daily living) self care deficit related to impaired balance, limited mobility, weakness. Interventions: .Transfer: May transfer with E-Z stand (mechanical transfer device) and assist of 1 except needs to use hoyer for out of bed transfers only. On 5/20/26 at 1:40 PM, Surveyor interviewed CNA J about mechanical lift transfers. CNA J stated that two staff members are needed for a hoyer transfer and one is needed for a stand, but I prefer two. Surveyor asked if CNA J is able to find assistance for transfers. CNA J stated yes, you walkie (walkie talkie) for them to come, or peek your head out of the room. Nurses will assist too. Surveyor asked how long it might take to get assist. CNA J stated it is usually quick; less than 5 minutes. Surveyor asked CNA J if R17 needs to wait for assist with transfers. CNA J stated there is usually no concern with wait time, but I have told R17 that it would be about 5 minutes before being able to get him/her up. If I move on to another resident, I always let them know that I'll be back and I or another staff goes in to do the transfer. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/26 at 7:47 AM, Surveyor interviewed CNA G and asked if R17 had concerns with waiting for assistance. CNA G stated R17 has concerns with specific people because they don't take his/her needs seriously; to put R17 to bed or take R17 to the toilet when he/she wants to. Surveyor asked how CNA G knows that R17 has a concern. CNA G stated when you go in R17s room you know if he/she had trouble because he/she won't talk; when you ask he/she opens up about the concerns. Then I talk to the nurse. On 5/21/26 at 8:27 AM, Surveyor interviewed CNA K who stated there was an incident this past weekend; I deescalated and made it better. I was in the dining room and my coworker told me that R17 needed to use the bathroom. Another situation arose, which I took care of. When I got to R17, I found out that the person who had gotten him dressed had just left him/her. R17 said the CNA came and washed me and got my shift in, then left. R17 was cussing and not liking her. During this situation, R17's light was on, one CNA was passing water and another CNA was passing trays; both told R17 they would let someone know. CNA J learned of the situation and confronted those CNAs; they admitted they didn't help R17. I let the nurses know. RN H (Registered Nurse) was here; I let him/her know. If a resident has a concern, I'd always tell DON B (Director of Nursing) or RN H. On 5/21/26 at 9:08 AM, CNA K clarified that there were 2 situations; R17 being left alone after getting half dressed was on Sunday and the 2 CNAs not answering R17's call light was on Saturday. CNA K stated it was the incident on Saturday that had been reported to RN H. On 5/21/26 at 8:42 AM, Surveyor interviewed RN H and asked what is done when a CNA reports that a resident has a concern in care. RN H stated call DON B and NHA A (Nursing Home Administrator), talk to the resident and start the grievance process. Surveyor asked about R17's concern from Saturday 5/16/26. RN H stated one person said that R17 was frustrated with one of the CNAs; someone was passing water and didn't ask when he/she needed. I did tell NHA A and DON B. I texted DON B and said that I was writing the CNA up. Surveyor asked if RN H spoke with R17. RN H stated no, it had already been dealt with and I was dealing with other things. On 5/21/26 at 8:55 AM, Surveyor interviewed CNA J who stated that on Saturday, 5/16/26, R17 had his light and that people had stopped and said they would get help, but they didn't get any help. CNA K and I saw his light on, he was very frustrated. R17 said that someone had passed his breakfast tray and another person had passed iced water, but neither told that help was needed. R17 said his/her light had been on for quite a while. He/she needed to use the bathroom, they say his/her light and didn't help. I couldn't understand why he/she was made to wait as he/she is an EZ stand transfer with one assist once up and he/she was in the chair. Surveyor asked what is done when a resident has a concern/complaint. CNA J stated get the info, apologize, and report to management. CNA K spoke with management. R17 was very upset; he/she was yelling/cussing. On 5/21/26 at 9:57 AM, Surveyor interviewed DON B and asked if a resident is upset due to needing to use the bathroom, and having staff stop in room without assisting, would this be considered a grievance. DON B stated yes, definitely. Surveyor asked if DON B was aware of R17 concerns. DON B stated no; would've expected to be updated and would've expected RN H to have spoken with R17. I would expect this to be followed through as a grievance. On 5/21/26 at 10:23 AM, Surveyor interviewed NHA A and asked if a resident is upset with care/perceived lack of care, is this a grievance. NHA A stated yes, it could potentially be neglect; we'd need to interview to rule out. Surveyor and NHA A discussed R17's voiced concerns. NHA A stated, I should have been notified.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 8 errors out of 29 opportunities that affected 3 out of 4 residents (R41, R21 & R33) included in the medication pass task, which resulted in an error rate of 27.59%.Staff administered R41's lisinopril and hydralazine at 9:15AM. R1's order is to administer at 8:00AM. Staff administered these medications late.Staff administered R21's acetaminophen and senna at 8:58AM. The order is to administer acetaminophen and senna at 7:30AM. Staff administered R21's gabapentin at 8:58AM. The order is to administer gabapentin at 7:00AM. Staff administered these medications late.Staff administered R33's carbidopa-levodopa and dabigatran etexilate at 9:22AM, metoprolol at 9:33AM, and oxybutynin at 9:23AM. These medications are ordered to be administered at 8:00AM. Staff administered these medications late. Staff administered R33 Magnesium 200mg at 9:24AM. R33's order is for Magnesium Gluconate 500mg. R33 received wrong medication and dose. Evidenced by:The facility policy entitled, Medication Administration Schedule, dated 11/2025, states, in part: . Policy Statement: Medications shall be administered according to established schedules.Policy Interpretation and Implementation:1. Medications are administered according to community protocol.3. A physician's order for specific times supersedes any routine schedule.The facility policy entitled, Medication Administration through Certain Routes, dated 6/2025, states, in part: . Applicability: . It ensures that medications are administered according to best practices, physician orders, and in compliance with current practice guidelines, and state and federal regulations. Example 1:R41 was admitted to the facility on [DATE] and has diagnoses that include hypertension (high blood pressure) and dementia (decline in cognitive abilities such as memory, reasoning and language).R41's Comprehensive Minimum Data Set (MDS) Assessment, dated 6/23/25 shows R41 has a Brief Interview of Mental Status (BIMS) score of 5 indicating R41 has severe cognitive impairment. R41's Physician Orders, dated 5/20/26, states, in part: . Lisinopril 20 mg (milligrams). Give 20 mg by mouth two times a day for hypertension. Start Date: 10/20/25.Hydralazine HCl (hydrochloride) 50 mg. Give 50 mg by mouth three times a day for hypertension. Start Date: 2/19/26. R41's MAR (medication administration record) states, in part: . Lisinopril (a medication to treat high blood pressure) 20 mg: Give 20 mg by mouth two times a day for hypertension. Start Date: 10/20/25. at 8:00AM & 8:00PM.Hydralazine HCl 50 mg. Give 50 mg by mouth three times a day for hypertension. Start Date: 2/19/26. at 8:00AM, 12:00PM & 5:00PM. R41's Administration History Report, dated 5/19/26 shows:-Hydralazine HCl 50 mg was administered on 5/19/26 at 9:15AM-Lisinopril 20 mg was administered on 5/19/26 at 9:15AM. On 5/19/26, at 9:15AM Surveyor observed RN C (Registered Nurse) administer R41's hydralazine and lisinopril.Note: These medications are ordered to be administered at 8:00AM. Example 2:R21 was admitted to the facility on [DATE] and has diagnoses that include constipation and pain.R21's Quarterly Minimum Data Set (MDS) Assessment, dated 12/26/25 shows R21 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R21 is cognitively intact.R21's Physician Orders, dated 5/20/26, states, in part: . Acetaminophen 325mg. Give 2 tablets orally two times a day for pain. Start Date: 4/30/26.Gabapentin 300mg. Give 1 capsule by mouth three times a day for pain. Start Date: 12/26/25.Senna S 8.6-50mg (Sennosides-Docusate Sodium). Give 2 tablets orally two times a day for constipation. R21's MAR (medication administration record) states, in part: . Acetaminophen Oral Tablet 325 mg. Give 2 tablets orally two times a day for pain. at 7:30AM & 4:00PM.Senna S Oral Tablet 8.6-50 mg (Sennosides-Docusate Sodium). Give 2 tablets orally two times a day for constipation. at 7:30AM & 4:00PM.Gabapentin Capsule 300mg. Give 1 capsule by mouth three times a day for pain. at 7:00AM, 12:00PM & 4:00PM. R21's Administration History Report, dated 5/19/26 shows:-Acetaminophen 650mg was administered on 5/19/26 at 8:58AM-Gabapentin 300mg was administered on 5/19/26 at 8:58AM-Senna S 8.6-50mg (2 tablets) was administered on 5/19/26 at 8:59AM On 5/19/26, at 8:59AM, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed RN C administer R21's acetaminophen, gabapentin and senna s.Note: Gabapentin is ordered to be administered at 7:00AM. Acetaminophen and Senna S are ordered to be administered at 7:30AM. Example 3:R33 was admitted to the facility on [DATE] and has diagnoses that include hypertension (high blood pressure), history of venous thrombosis (a blood clot in a deep vein) and embolism (clot that breaks loose and travels to the lungs), and chronic pain syndrome. R21's Comprehensive Minimum Data Set (MDS) Assessment, dated 5/6/26 shows R21 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R21 is cognitively intact.R21's Physician Orders, dated 5/20/26, states, in part: . Carbidopa-Levodopa Oral Tablet 25-100 mg. Give 1.5 tablets by mouth two times a day. Start Date: 5/16/26.Dabigatran Etexilate Mesylate Oral Capsule 150mg. Give 1 capsule by mouth two times a day for DVT (Deep Vein Thrombosis) prophylaxis. Start Date: 5/06/26.Metoprolol Tartrate Oral Tablet 25 mg. Give 1 tablet by mouth two times a day for hypertension. Start Date: 5/06/26.Oxybutynin Chloride Oral Tablet 5mg. Give 1 tablet by mouth two times a day for overactive bladder. Start Date: 5/09/26.Magnesium Gluconate Oral Tablet 500mg. Give 1 tablet by mouth one time a day for supplement. Start Date: 5/10/26. R33's MAR (medication administration record) states, in part: . Magnesium Gluconate Oral Tablet 500 mg. Give 1 tablet by mouth one time a day for supplement. Start Date: 5/07/26. at 6:00AM-10:00AM.Carbidopa-Levodopa Oral Tablet 25-100mg. Give 1.5 tablets by mouth two times a day. Start Date: 5/16/26. at 8:00AM & 2:00PM.Dabigatran Etexilate Mesylate Oral Capsule 150mg. Give 1 capsule by mouth two times a day for DVT prophylaxis. Start Date: 5/06/26. at 8:00AM & 8:00PM.Metoprolol Tartrate Oral Tablet 25mg. Give 1 tablet by mouth two times a day for hypertension. Start Date: 5/06/26. at 8:00AM & 8:00PM.Oxybutynin Chloride Oral Tablet 5mg. Give 1 tablet by mouth two times a day for overactive bladder. Start Date: 5/09/26. at 8:00AM & 8:00PM R33's Administration History Report, dated 5/19/26 shows:-Carbidopa-Levodopa was administered on 5/19/26 at 9:22AM-Dabigatran Etexilate Mesylate was administered on 5/19/26 at 9:22AM-Metoprolol Tartrate was administered on 5/19/26 at 9:33AM-Oxybutynin chloride was administered on 5/19/26 at 9:23AM-Magnesium Gluconate 500mg was administered on 5/19/26 at 9:24AM On 5/19/26 at 9:33AM, Surveyor observed RN C administer magnesium 200mg, oxybutynin, metoprolol, dabigatran etexilate, and carbidopa-levodopa to R33. Note: The order is for magnesium gluconate 500mg. The order is for oxybutynin, metoprolol, dabigatran etexilate, and carbidopa-levodopa to be administered at 8:00 AM. On 5/19/26 at 2:15PM, DON B (Director of Nursing) indicated medications ordered at a specific time such as 8:00AM means the medication can be administered an hour before 8:00AM up to an hour after 8:00AM. Medications ordered 6:00AM-10:00AM must be administered during that time.On 5/20/26 at 8:56AM, Surveyor interviewed DON B and reviewed the medication administration history report for R41, R21, and R33 for 5/19/26 morning medication pass. DON B indicated she would expect medications ordered at 8:00AM to be administered by 9:00AM and medications ordered for 7:30AM to be administered by 8:30AM. Medications ordered from 6:00AM-10:00AM should be administered within that time. Medications on the MAR for a specific time should be administered an hour after the scheduled time. DON B agreed R21, R41, and R33 medications administered late were medication errors. DON B indicated the magnesium 200mg administered to R33 was the wrong medication and dose. R33's medication order is for magnesium gluconate 500mg. DON B indicated this is a medication error. On 5/20/26, at 9:10AM, Surveyor interviewed RN C. Surveyor asked for medications ordered at a specific time when should the medications be administered. RN C indicated an hour before the scheduled time up to an hour after the scheduled time. RN C indicated for medications scheduled to be administered 6:00AM-10:00AM must be administered during that time. Surveyor reviewed the times R21, R41, and R33 received their medications on 5/19/26. RN C indicated R21, R33, and R41's medications were administered late on 5/19/26 for the morning medication pass. Surveyor asked if medications administered late would be a medication error and RN C indicated it would not be classified as an error but late. Surveyor asked RN C what R33's order for magnesium is. RN C looked at the orders and indicated magnesium gluconate 500mg. Surveyor brought to RN C's attention that magnesium 200mg (continued on next page)

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	525445	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Health and Rehab	825 Western Ave. Columbus, WI 53925

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was administered on 5/19/26. RN C pulled out R33's bottle of magnesium and verified it was the wrong medication and dose. RN C indicated she would notify the physician to get the order changed as R33's magnesium was brought from home.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure to develop and implement written policies and procedures that: S483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 8 staff reviewed for background checks.CK D (cook) was hired by the facility on 3/18/26. CK D's Background Information Disclosure (BID) Form, dated 3/18/26, indicated he lived in Iowa and [NAME] Virginia in the last three years. The facility did not do a background check for Iowa or [NAME] Virginia.Evidenced by:The facility policy entitled, F606, F607 Abuse Prevention Program, Screening of Employees, dated 10/25, states, in part: . Policy: The community will not employ or otherwise engage individuals whom have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, entered into the State nurse aide registry or against the professional license they hold with the state licensure body.Guidelines:1. Background checks are completed per state guidelines on each employee.2. Pre-employment screening will consist at a minimum: a. Employment history b. Information from former employers as available, andc. Documentation of status and any disciplinary actions from licensing or registration boards or registries.9. Regardless of the source of the check, maintain the document that the screening occurred.CK D (cook) was hired by the facility on 3/18/26. CK D's Background Information Disclosure (BID) Form, dated 3/18/26, indicated he lived in Iowa and [NAME] Virginia in the last three years. The facility did not do a background check for Iowa or [NAME] Virginia.On 5/20/26, at 10:38AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor reviewed CK D's BID that indicated CK D had lived in Iowa and [NAME] Virginia in the past three years. Surveyor asked NHA A if CK D had a background check for Iowa and [NAME] Virginia. NHA A looked through CK D's file and could not see one. NHA A reached out to business office manager, who was out on medical leave. NHA A returned to Surveyor and indicated the background checks for Iowa and [NAME] Virginia had been missed and should have been completed. NHA A indicated she had filed for the background check, and it is pending at this time. Surveyor informed NHA A there was a concern for the background checks not being completed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law through established procedures for 1 of 14 Residents (R17) reviewed for abuse.R17 reported an allegation of neglect and the facility did not submit a report to the State Agency (SA).Evidenced by:The facility's F609, Reporting of Abuse Allegation policy, dated 10/25, states, in part: All suspected violations and all substantiated incidents of abuse, neglect, exploitation or mistreatment, including injuries of unknown sources and misappropriation will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law.Definitions: Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another rhealth care provider, or others but has not yet been investigated and, if verifited, could be noncompliance with the Federatl requirements related to mistreatment, exploitation, neglect, abuse, including injuries of unknown source, and misappropriation of resident property. Guidelines .2. Should a suspected vilation or a reasonable suspicion or substantiated incident of mistreatement, neglect, injuries of an unknown source, or abuse be reported, the facility administrator, or his/her designee in their absence, will promptly notify the following persons or agencies (verbally and written) of such incident: a. The State licensing/certification agency responsible for surveying/licensing the facility; .R17 admitted to the facility on [DATE] and has diagnoses that include: cervical disc disorder with myelopathy, mid-cervical region (a progressive condition where a degenerated or herniated disc in the neck compresses the spinal cord, leading to loss of coordination, balance issues, and muscle weakness); Need for Assistance with personal care; muscle weakness; lack of coordination.R17's MDS (Minimum Data Set), dated 2/18/26, indicates a BIMS (Brief Interview for Mental Status) score of 15, indicating R17 is cognitively intact.On 5/21/26 at 7:47 AM, Surveyor interviewed CNA G (Certified Nursing Assistant) regarding R17. CNA G stated that a couple of week ago, R17 stated that he/she had not been changed all night. CNA G stated he/she told DON B (Director of Nursing) and RN H (Registered Nurse).On 5/21/26 at 7:57 AM, Surveyor interviewed LPN I (Licensed Practical Nurse) and asked what is done if a resident says no one has helped them all night. LPN I stated ask the cna what they noticed, is the resident soiled. Look for documentation. Talk to the resident, take care of their need. Talk to the staff the next night. Surveyor asked if anyone else is talked to. LPN I stated he/she would speak with DON B. Surveyor asked about R17. LPN I stated there was one morning where R17 claimed he/she wasn't cared for; when I spoke with the CNA it sounded like a refusal. I don't think I was the nurse on that hall, I think I had stopped to assist. The resident told the CNA and myself. I shared with the nurse, so I felt it was handled.On 5/21/26 at 8:42 AM, Surveyor interviewed RN H and asked what is done if a CNA reports that a resident has a concern with their care. RN H stated call the DON (Director of Nursing) and NHA (Nursing Home Administrator), talk to the resident, and start the grievance process. Surveyor asked about R17 voicing concern of not being changed all night. RN H stated not that I know of. Surveyor asked what would happen if this was reported. RN H stated I'd talk to the resident and tell DON B and NHA A (Nursing Home Administrator).On 5/21/26 at 9:37 AM, Surveyor interviewed R17 and asked if there had been a concern of not being cared for during the night. R17 stated yes, the CNAs shift was from 10:00 PM to 6:00 AM; usually they will come in about 3-4 times during the night; he/she had come in around 11:00 PM and asked if I was dry, I said yes, and he/she left. He/she didn't talk with me the rest of the night. He/she came back in at 5:00 AM, when the shift was almost over. He/she should've checked on me, I need to be changed a couple of times during the night, but he/she didn't check. Surveyor asked if R17 told anyone. R17 stated yes, I tell whoever is on duty.On 5/21/26 at 9:57 AM, Surveyor interviewed DON B and asked if it is a potential (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation of neglect if a resident says they didn't get changed all night. DON B stated yes, we'd need to investigate and report. Surveyor asked if it had been reported to DON B that R17 stated that a couple weeks ago R17 hadn't been changed all night. DON B stated, not that I am aware of.On 5/21/26 at 10:23 AM, Surveyor interviewed NHA A and asked if it is a potential allegation of neglect if a resident says they didn't get changed all night. NHA A stated yes, would need to self report the allegation of neglect, protect the resident through investigation of the alleged perpetrator, remove that person from the building/suspend pending investigation, interview other staff and residents. Surveyor asked if R17's concern was reported. NHA A stated no, I didn't know about this until now; it should've been reported. We did do a lot of education on May 5 and 6 regarding grievances and abuse. I will start the investigation and submit a report.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not investigate an alleged violation of neglect for 1 of 14 residents (R17) reviewed for abuse.R17 reported to CNA G that R17 hadn't been changed/cared for all night. The facility did not complete an investigation.Evidenced by:The facility's F607 Abuse Prevention Program, Investigation F600, F602, F603, F610, dated 10/25, states, in part: Reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management.1. Should an incident or suspected incident of resident abuse, mistreatment, misappropriation, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.R17 admitted to the facility on [DATE] and has diagnoses that include: cervical disc disorder with myelopathy, mid-cervical region (a progressive condition where a degenerated or herniated disc in the neck compresses the spinal cord, leading to loss of coordination, balance issues, and muscle weakness); Need for Assistance with personal care; muscle weakness; lack of coordination.R17's MDS (Minimum Data Set), dated 2/18/26, indicates a BIMS (Brief Interview for Mental Status) score of 15, indicating R17 is cognitively intact.On 5/21/26 at 7:47 AM, Surveyor interviewed CNA G (Certified Nursing Assistant) regarding R17. CNA G stated that a couple of weeks ago, R17 stated that he/she had not been changed all night. CNA G stated he/she told DON B (Director of Nursing) and RN H (Registered Nurse).On 5/21/26 at 7:57 AM, Surveyor interviewed LPN I (Licensed Practical Nurse) and asked what is done if a resident says no one has helped them all night. LPN I stated ask the CNA what they noticed, is the resident soiled. Look for documentation. Talk to the resident, take care of their need. Talk to the staff the next night. Surveyor asked if anyone else is talked to. LPN I stated he/she would speak with DON B. Surveyor asked about R17. LPN I stated there was one morning where R17 claimed he/she wasn't cared for; when I spoke with the CNA it sounded like a refusal. I don't think I was the nurse on that hall, I think I had stopped to assist. The resident told the CNA and myself. I shared with the nurse, so I felt it was handled.On 5/21/26 at 8:42 AM, Surveyor interviewed RN H and asked what is done if a CNA reports that a resident has a concern with their care. RN H stated call the DON (Director of Nursing) and NHA (Nursing Home Administrator), talk to the resident, and start the grievance process. Surveyor asked about R17 voicing concern of not being changed all night. RN H stated not that I know of. Surveyor asked what would happen if this was reported. RN H stated I'd talk to the resident and tell DON B and NHA A (Nursing Home Administrator).On 5/21/26 at 9:37 AM, Surveyor interviewed R17 and asked if there had been a concern of not being cared for during the night. R17 stated yes, the CNAs shift was from 10:00 PM to 6:00 AM; usually they will come in about 3-4 times during the night; he/she had come in around 11:00 PM and asked if I was dry, I said yes, and he/she left. He/she didn't talk with me the rest of the night. He/she came back in at 5:00 AM, when the shift was almost over. He/she should've checked on me, I need to be changed a couple of times during the night, but he/she didn't check. Surveyor asked if R17 told anyone. R17 stated yes, I tell whoever is on duty.On 5/21/26 at 9:57 AM, Surveyor interviewed DON B and asked if it is a potential allegation of neglect if a resident says they didn't get changed all night. DON B stated yes, we'd need to investigate and report. Surveyor asked if it had been reported to DON B that R17 stated that a couple weeks ago R17 hadn't been changed all night. DON B stated, not that I am aware of.On 5/21/26 at 10:23 AM, Surveyor interviewed NHA A and asked if it is a potential allegation of neglect if a resident says they didn't get changed all night. NHA A stated yes, would need to self report the allegation of neglect, protect the resident through investigation of the alleged perpetrator, remove that person from the building/suspend pending investigation, interview other staff and residents. Surveyor asked if R17's concern was reported. NHA A stated no, I didn't know about this until now; it should've been reported. I will start the investigation and submit a report.

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	525445	A. Building B. Wing	05/21/2026

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F 0689 Level of Harm - Minimal harm or potential for 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 each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 1 residents (R24) reviewed for elopement.The facility did not accurately assess R24's risk for elopement, did not update R24's care plan with personalized interventions when Interdisciplinary team came up with interventions to prevent elopements, and did not follow care planned interventions of increased supervision. R24 was found to be outside ambulating independently.Evidenced by:The facility did not provide a policy related to Elopement.R24 admitted to the facility on [DATE] with diagnoses including dementia.R24's Hospital Discharge Note, dated 10/24/25, includes: . Reason for admission and hospital course: The patient . who comes to . hospital with increasing confusion. She had been wandering outside of her house. She was brought in to emergency room.R24's Elopement Risk Assessment, dated 10/24/25, includes: New Admission. BIMS (Brief Interview for Mental Status) available: no. Orientation: person. The resident is non-ambulatory: No. Resident exhibits forgetfulness or shortened attention span and is independently mobile: unchecked. Wandering/Exit Seeking Patterns: Check all that apply- History of wandering at home or other setting, including current setting, with or without purpose- checked, history of exit seeking at home or other setting, including current setting- unchecked. Factors: check all that apply- new roommate last 30 days? (blank). New room last 30 days, including move to another unit: (blank). Recent admission past 30 days- checked. Verbalizes hallucinations last 30 days- unchecked. Current evaluation: lacks safety awareness of current situation- checked. Diagnoses: Dementia- unchecked. Alzheimer's unchecked. Score: 8 low risk.(It is important to note the risk assessment does not reflect R24's moments of forgetfulness, diagnosis of dementia, or history of exit seeking. R24 scored low as an elopement risk, but this was why she went to the hospital to begin with.)R24's Social Services Note, dated 10/27/25, includes, in part: . She is alert and oriented times 2.R24's Comprehensive Care Plan, updated on 10/28/25 to include: R24 has a potential for an elopement/wandering due to poor safety awareness, history of wandering and cognitive deficits.Goal- R24 will remain safe within the designated confines of the community. Interventions- Encourage as much participation in activities that the resident can endure or comprehend. Give clear explanations of all care to be provided. Increase R24's supervision by the staff during increased exit seeking or unsafe wandering.R24's Nurse Note, dated 11/19/25, includes: . Exit seeking behavior first half of shift. Needed one on one supervision for safety. Daughter called per resident request and daughter came in briefly around supper to visit resident and was updated on resident's behavior.R24's Interdisciplinary Team Note, dated 11/21/25, includes: . Resident exhibiting exit seeking behaviors in the evening this week. Resident reports that she needs to get home and believes her house is just down or across the street. Wanderguard in place and staff ensure proper placement and functioning every shift. Resident is able to be redirected away from exits. Plan- Staff continue to offer diversional activities and redirection away from exits during periods of exit seeking. Resident provided reassurance during these times that she is in facility receiving therapy at this time and that family knows she is here. Daughters called on phone at times to also reassure resident that they know she is here and safe in the facility.(It is important to note the interventions mentioned in the Plan by the Interdisciplinary Team of providing reassurance to R24 by voicing to her that she is at the facility to receive therapy and her family knows she is here. Also important to note these interventions are not added or included in R24's Comprehensive Care Plan.)R24's Elopement Risk Assessment, dated 12/9/25, includes: BIMS available: yes. BIMS score: (blank). Resident exhibits forgetfulness or shortened attention span and is independently mobile: unchecked. Wandering/Exit Seeking Patterns: check all that apply- history of wandering at home or other setting with or without purpose- checked, history of exit seeking at home or other setting, including current setting- unchecked, stays near exit doors- unchecked, wanders (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after dark/sundowns- unchecked, talks about leaving, expresses desires to leave- unchecked.(It is important to note that the following are not checked on R24's Elopement Risk Assessment: stays near exit doors, history of exit seeking at home or other setting. Including current setting, wanders after dark/sundowns, talks about leaving, expresses desires to leave while Nurse Notes indicate R24 is having exit seeking behaviors around supper/possibly sundowning, resident able to be redirected from exits during periods of exit seeking.)R24's Nurse Note, dated 1/26/26, includes: . at 1915, alarm sounded at back door of end of . hallway. Staff ran down to door and noted R24 was right outside back door and was ambulating. Chair was inside building in hallway. Staff assisted R24 back into building and into wheelchair. Was wearing sweatshirt, pants, and gripper socks at time of incident. No further attempts. Wander guard in place on wrist and functioning properly.(It is important to note R24 was independently mobile and had eloped/walked out the door of the building.)R24's Nurse Note, dated 1/27/26, includes: . Note Text: Report from previous shift that R24 attempted to elope the facility through a side door with no coat or shoes on. Staff have been attempting to redirect her all night. R24 has come out of her room multiple times roaming. While staff were away from the nursing station, R24 attempted to go through the front door. Staff redirected her and put her into bed. Night shift has been doing 30 minute checks for safety.R24's Interdisciplinary Team Note, dated 1/27/26, includes: Resident had a noted elopement attempt on 1/26/26. Following supper meal, resident noted to be more confused thinking family or friends were coming to pick her up. Resident redirected by staff. At approximately 1915, staff heard the 300 wing emergency exit doors alarm and responded immediately. Resident was noted to have left wheelchair at the end of the hallway near the emergency exit door and was ambulating through the emergency exit doors. Staff member was able to immediately redirect her back inside and into wheelchair. Plan : Resident continues to have functioning wandergard in place due to known elopement risk. Contributing factors to increase in behaviors identified as recent COVID infection with newly discontinued isolation precautions that may result in need for reorientation to facility secondary to dementia.(It is important to note R24 was noted to be more confused and required staff redirection, but staff only heard the emergency exit door alarm and had not increased R24's supervision per R24's care plan and R24 was found outside ambulating independently.)R24's Elopement Risk Assessment, dated 1/27/26, indicates R24 is a low risk for elopement with a score of 4. The assessment includes: . Is BIMS available- No . BIMS score (blank) . Wandering/exit Seeking Patterns: Check all that apply. Resident exhibits forgetfulness or shortened attention span and is independently mobile- unchecked. History of wandering at home or other setting, including current setting, with or without purpose- unchecked . History of exit seeking at home or other setting, including current setting- unchecked . Stays near exit doors- unchecked . Wanders after dark/sundowns- unchecked. Talks about leaving- unchecked . Lacks safety awareness of current situation- unchecked . Current state of agitation or restlessness- unchecked . (It is important to note R24 had an actual elopement/got outside of the building and her score is now lower indicating she is less of a risk for elopement then before she eloped. It is important to note R24's elopement risk assessment is inaccurate and incomplete.)R24's Comprehensive Care Plan, updated on 1/27/26, to include: Do one on one with (R24) if agitated.R24's Nurse Note, dated 1/30/26, includes: Resident with noted increase in restlessness, agitation, and exit seeking earlier this week. Staff provided increased supervision and redirected resident to ensure safety during episodes of exit seeking. Resident behaviors much improved at the end of the week with no current exit seeking behaviors noted at this time. Staff continue to assist resident with redirection during behavioral episodes.R24's Elopement Risk Assessment, dated 2/16/26 indicates R24 is a moderate risk for elopement with a score of 13.R24's Comprehensive Care Plan, updated 2/16/26, to include: Assess for pain, hunger, thirst or toileting needs with increase restlessness. R24's Interdisciplinary Team Note, dated 2/20/26, includes: Resident was noted to have an increase in behaviors and impaired mood yesterday. Resident exhibiting wandering and exit seeking and was noted to be irritable with staff and family. Resident was able to be redirected during wandering/exit seeking episodes. New (continued on next page)

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Columbus Health and Rehab	825 Western Ave. Columbus, WI 53925

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 - Minimal harm or potential for actual harm Residents Affected - Few	order Seroquel 12.5mg (milligrams) every 8 hours as needed for agitation for 14 days. She had been exhibiting exit seeking behaviors, experienced increased restlessness, and agitation.R24's Elopement Risk Assessment, dated 4/13/26, includes: . Orientation- person. BIMS available- yes. BIMS- (blank). Wandering/Exit Seeking Patterns- check all that apply. History of wandering at home or other setting, with or without purpose- checked, history of exit seeking at home or other setting, including current setting- checked, packs belongings to go home- unchecked, stays near exit doors- unchecked, wanders after dark/sundowns- unchecked, talks about leaving, expresses desires to leave- checked. Verbalizes hallucinations in the last 90 days- unchecked. Current Evaluation- lacks safety awareness- checked. Current state of agitation of restlessness- unchecked. Diagnoses- dementia- checked. Current Medications: none checked. Score- 9 low risk.(It is important to note this assessment does not reflect R24's behaviors of staying near exit doors, having moments of restlessness, and is incomplete as R24's BIMS scores are not included.)R24's Nurse Note, dated 5/13/26, includes: Resident has been quite restless this AM shift. Resident up early and took medications, noted to self transfer to wheelchair and attempt to make a phone call from a phone in the hallway. Resident assisted to sit back down but then proceeded to wander the halls in her wheelchair, attempting to exit at each door she found. Staff able to intervene and redirect.On 5/21/26 at 8:50 AM DON B (Director of Nursing) indicated assessments should be complete and accurate. DON B indicated R24's elopement risk assessments were not complete or accurate. DON B indicated R24's care plan should be updated timely and include personalized/individual interventions that the Interdisciplinary Team comes up with.On 5/21/26 at 1:29 PM NHA A (Nursing Home Administrator) indicated assessments should be complete and accurate. NHA A indicated R24's care plan should have been updated with interventions discussed by the Interdisciplinary Team. NHA A indicated R24's elopement risk assessments are not accurate and are not complete.