STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525622	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soldiers Grove Health Services	101 Sunshine Blvd Soldiers Grove, WI 54655

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 1 of 1 resident reviewed for grievances (R13). R13 expressed concerns regarding asking for assistance with ADLs (Activities of Daily Living) that was not completely investigated by the facility. Evidenced by: The facility's policy titled Grievance Policy dated 7/2022 states in part .When a Complaint/ Grievance Report is initiated: .The original form will then be forwarded to the department head for which the Grievance pertains to (i.e. Dietary Manager for food and dining related issues, DON (Director of Nursing) for any nursing or clinical related issues.). The Department Head that is assigned the concern form is responsible for investigating the issue within 72 hours of being assigned the grievance. The Grievance Officer will ensure: during the investigation, the Grievance Officer will prevent any potential or further violation of resident rights.The Grievance Officer will ensure that: .written grievance resolution decisions include the date when the original concern was received, a summary statement of the concern, steps taken to investigate, a summary of findings or conclusions regarding the concern, whether the concern was confirmed or not, any corrective action taken and the date the decision was issued. R13 was admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left sided weakness/ paralysis following a stroke), pain, major depressive disorder, and hypertension (high blood pressure). R13's most recent MDS (Minimum Data Set) dated 5/30/25, states that R13 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R13 is cognitively intact. The MDS also states that R13 requires partial/ moderate assistance with lower body dressing and personal hygiene. R13's care plan dated 11/13/24 states in part .Focus: ADL self- care deficit evidenced by: CVA (Cerebral Vascular Accident (stroke)). Goal: Will maintain existing ADL self performance [sic]. Interventions/ Tasks: .Personal Hygiene: Independent with set up of items (revised on 5/20/25) . It is important to note that R13's care plan does not address the amount of assistance that they require with dressing. On 5/28/25 a grievance form was filled out for R13. The form states in part:.Detail of complaint/ grievance: Resident upset d/t (due to) not getting enough help with ADLs. Resident is independent with ADLs and often refuses to dress himself.Person completing this form: NHA A. Person investigating complaint/ Grievance: NHA A/ SSD (Social Services Director). Grievance official follow-up: Resident interviewed by myself and SSD. Resident continues to be upset when independence is referenced. States can't do things all on own, then begins to perseverate on therapy. Writer redirects without success, SSD redirects. No resolution as resident continues to believe he should not be independent and d/c (discharged) from therapy.Date resolved: 5/28/25. Resident is not satisfied but needs to move toward independence with ADLs to return to community. On 7/15/25 at 10:20 AM, Surveyor interviewed R13. R13 reported to Surveyor that they do not get the help they need with dressing, and that staff tell them they can do it themself. On 7/17/25 at 8:26 AM, Surveyor interviewed PTA M (Physical Therapy Assistant) and COTA N (Certified Occupational Therapy Assistant). Surveyor asked PTA M and COTA N if R13 was being seen by therapy, PTA M stated no. Surveyor asked what R13's ADL abilities are, PTA M stated that he was independent in his room, but was asking for some help and that R13 had been transferring independently in the bathroom but was still asking for help. Surveyor asked PTA M and COTA N if R13 is independent with all ADLs, COTA N stated that R13 reported that he could do it, and that he said he was able to put his shirt and pants on by himself. Surveyor asked COTA if there was any documentation of R13's abilities, COTA N stated that there weren't any notes. On 7/17/25 at 2:16 PM, Surveyor interviewed NHA A. NHA reported that he was the Grievance Official. Surveyor asked NHA A what the process is for investigating a grievance, NHA reported that he receives the grievance, the grievance form gets filled out, they assign someone to investigate the concern, he reviews the investigation, follows- up with the resident/ resident representative. Surveyor asked NHA to explain the investigation completed in regard to R13's grievance, NHA A stated that R13 didn't want to be discharged from therapy, wanted assistance with ADLs, and stated that he was not independent. Surveyor asked NHA A if he interviewed CNAs (Certified Nursing Assistants) regarding R13's need for assistance, NHA A stated yes. Surveyor asked NHA A if the interviews were documented, NHA A stated no. Surveyor asked NHA A if therapy was consulted and the recommendations were reviewed, NHA A stated that therapy reported that R13 is independent. Surveyor asked NHA A if R13 was re-evaluated by therapy after this incident, NHA A stated yes. Surveyor requested therapy documentation OT (Occupational Therapy)

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities (continued on next page)

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:1Number of residents cited:1Based on interview and record review, the facility did not follow through with the appropriate steps of the Preadmission Screening and Resident Review (PASRR) process for 1 of 1 resident (R8) reviewed.The facility does not provide R8 with specialized services per PASAAR Level 2 recommendations.Evidenced by:Per the facility, they do not have a PASRR Policy and Procedure.According to Wisconsin Department of Health Services at https://www.dhs.wisconsin.gov>pasrr, states, in part: . Preadmission Screening and Resident Review (PASRR) is a federal requirement established to identify individuals with mental illness and/or intellectual developmental disability to ensure appropriate placement in the community or a nursing facility.In brief, PASRR requires all applicants to Medicaid-certified nursing facilities be assessed to determine whether they might have an intellectual disability or mental illness. This is called a Level I screen. The purpose of a Level I screen is to identify individuals whose total needs require that they receive additional services for their intellectual disabilities or serious mental illness. Individuals who test positive at Level I are then evaluated in depth to confirm the determination of an intellectual disability or mental illness for PASRR purposes. This is a Level II screen. This assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care.Purposes of PASRREvaluate individuals seeking admission to nursing facilities and current nursing facility residents to determine if they have a serious mental illness or an intellectual disability. Identify the individual's strengths and needs.Determine if the individual needs specialized psychiatric rehabilitation services to address his/her mental illness issues or specialized services to address his/her mental illness or intellectual disability issues.Determine if the individual needs placement in a nursing facility versus placement in an inpatient psychiatric hospital, institution for mental diseases, intermediate care facility for individuals with intellectual disabilities, or a community setting (example: group home).Notify the client or the client's legal representative and other appropriate parties of the results of the evaluations and the determinations.R8 admitted to the facility on [DATE] and has diagnoses that include severe intellectual disabilities (a significant cognitive impairment and adaptive behavior limitations, impacting daily life and requiring substantial support).R8's Care Plan dated 10/12/22, states, in part: . Focus: R8 is in need of specialized services due to diagnosis of severe intellectual disability and cerebral palsy. Date Initiated: 10/12/2022.Goal: R8 will maintain or improve her current level of functioning. Date Initiated: 10/12/2022. Revision on: 10/06/2025. Target DATE: 10/06/2025.R8 will be encouraged to make self-decisions as able. Date Initiated: 10/12/2022. Revision on: 7/09/2025. Target Date: 10/06/2025.Interventions/Tasks:Physical therapy, occupational therapy, socialization and Leisure. R8 enjoys group activities and coloring. Date Initiated: 10/12/2022.R8's PASRR Level 1 Screen was completed on 9/27/22 and was indicative of a PASRR Level II.R8's PASRR Level II dated 10/05/22, states, in part: . No- support for the diagnosis of a severe medical condition was not found OR documentation was not found that indicates that the person's level of functioning is so severely impaired by his/her medical condition that he/she could not be expected to actively participate or benefit from specialized services.Yes, this person is appropriate for a placement in a nursing facility.This person has both an intellectual developmental disability and a serious mental illness.This person needs specialized services to address his/her developmental disability needs.On 7/21/25, at 11:45 AM, Surveyor interviewed SSD D (Social Services Director) and asked if R8 requires specialized services for her intellectual disability and SSD D indicated there was confusion with the PASRR Level II as the facility received on stating R8 needed specialized services and another PASRR Level II stating she did not require specialized services both dated 10/05/22. SSD D indicated the facility was informed it was up to them as to provide the specialized services or not. Surveyor asked if SSD D could provide documentation of that. SSD D indicated it was through emails and faxes, and she would look. No documentation was provided to Surveyor. Surveyor asked SSD D how the facility interpreted the Level II. SSD S indicated the facility care planned R8 as needing specialized services. Surveyor asked SSD D what specialized services are being provided to R8. SSD D indicated the facility was using therapy at one time and activities. At one point the facility could use PT/OT and then at one point the facility could use activities. Surveyor asked if those are considered specialized services and if all residents can receive those and SSD D indicated yes all residents can receive those services. Surveyor asked at this time what services are being provided to R8 and SSD D indicated she doesn't think she has any services in place right now. SSD D indicated as far as follow up to

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 12Number of residents cited:1Based on interview and record review the facility did not develop a comprehensive care plan or review and revise the comprehensive care plan for 1 of 12 sampled residents (R13).R13's care plan did not address the type of assistance required for dressing.Evidenced by:The facility's policy titled Comprehensive Care Plan revised on 9/23/22 states in part .1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care.3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well- being.R13 was admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left sided weakness/ paralysis following a stroke), pain, major depressive disorder, and hypertension (high blood pressure). R13's most recent MDS (Minimum Data Set) dated 5/30/25, states that R13 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R13 is cognitively intact. The MDS also states that R13 requires partial/ moderate assistance with lower body dressing and personal hygiene.R13's care plan dated 11/13/24 states in part .Focus: ADL(Activities of Daily Living) self- care deficit evidenced by: CVA (Cerebral Vascular Accident (stroke)). Goal: Will maintain existing ADL self performance [sic]. Interventions/ Tasks: .Personal Hygiene: Independent with set up of items (revised on 5/20/25) .It is important to note that R13's care plan does not address the amount or type of assistance that they require with dressing.OT (Occupational Therapy) Discharge summary dated [DATE] states in part: .Dressing: Upper body dressing = Supervision or touching assistance. Lower body dressing = Partial/ moderate assistance. Putting on/ taking off footwear = Partial/ moderate assistance.On 7/15/25 at 10:20 AM, Surveyor interviewed R13. R13 reported that he is not getting the help that he needs from facility staff.On 7/17/25 at 9:34 AM, Surveyor interviewed CNA O (Certified Nursing Assistant). Surveyor asked CNA O how much assistance R13 requires with ADLs, CNA O stated that R13 is supposed to be independent, but R13 needs assistance with putting on his socks and pants but can put his shirt on by himself most of the time. Surveyor asked CNA O what R13's care plan says about the amount of assistance he requires, CNA O stated that it says he's independent. Surveyor and CNA O reviewed R13's care plan. After reviewing the care plan, Surveyor asked CNA O if the care plan states that R13 is independent with dressing, CNA O stated no. Surveyor asked CNA O if the care plan addresses R13's ability to dress, CNA O stated no.On 7/17/25 at 2:50 PM, Surveyor interviewed R13. Surveyor asked R13 what ADLs he was able to complete on his own once discharged from therapy, R13 stated that he was able to walk to therapy and take himself to the bathroom. Surveyor asked if he was able to dress himself, R13 stated no and that he needs assistance.On 7/21/24 at 9:54 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the process is for putting therapy recommendations onto the care plan, DON B stated that therapy gives the recommendations to the nurses and the nurses update the care plan. Surveyor asked DON B if she was aware that OT's recommendation for R13's dressing was partial/ moderate assist, DON B stated no. Surveyor asked DON B if she would expect that to be on R13's care plan, DON B stated yes.

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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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident receives the necessary care and services in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 of 13 sampled residents (R20) resulting in actual harm. R20 was self-transferring multiple times and on the eighth attempt, suffered an unwitnessed fall. The facility failed to provide an assessment completed by an RN (Registered Nurse) or with RN oversight at the time of the fall. The facility failed to notify the physician timely of the fall, failed to relay all of R20's symptoms to physician and DON B (Director of Nursing) at the time of the fall, and failed to notify physician of changes of condition following the fall. R20 was found to have a left acetabular (hip joint socket) fracture. Evidenced by:Facility policy, titled Change in Condition of the Resident, reviewed 9/20/22, includes, in part: .When a resident presents with a possible change in condition, after a fall or other possible trauma, or noted changes in mental or physical functioning: assess the resident's need for immediate care/medical attention. Provide emergency care as needed. Assessment/evaluation could include, but is not limited to, the following: vital signs, oxygen saturation, blood glucose level .lacerations - amount of bleeding drainage, size/depth of wound, dressings/condition of - if in place.Swelling, edema, discoloration.pain- location, type, intensity, duration, causative factors . alteration in level of consciousness, ability to respond . bowel and bladder control, sensory weakness or change.speech disorder.abdominal spasms or pain . Flushing, cyanosis, blanching.Abduction, adduction, shortening or improper position of extremities.Notify resident's physician.Immediate notification for any symptoms and signs or apparent discomfort, or a marked change in relation to usual symptoms and signs, or unrelieved by measures already prescribed requires a phone call to the provider . Do not fax for issues requiring immediate notification.Non immediate notification: Notifications that do not require immediate consultation with physician . Notify resident's family/responsible party as applicable and in accordance with resident's wishes. Monitor resident's condition frequently until stable or transported to a higher level of care .ensure resident's change in condition is included on the 24 hour report to be reviewed later . Documentation needs to include, but is not limited to the following: description of change in condition noted and assessment or observation of findings, emergency care provided, notification of physician, notification of appropriate party .According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) 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 (Licensed Practical Nurse) or less skilled assistants.(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.R20 admitted to the facility initially on 10/14/24 and has diagnoses that include paroxysmal atrial fibrillation (irregular rapid heart rate), unspecified fracture of left acetabulum (hip joint socket), acute kidney failure, hypothyroidism, benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland that can cause urination difficulty), other obstructive and reflux uropathy (abnormality of the urinary tract).R20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/20/25, indicates R20's cognition is severely impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Section GG of this assessment indicates R20 needed substantial/maximum assist for toileting, going from sit to stand, and supervision or touching assist for walking.R20's Fall/Risk Management Report titled Un-witnessed Fall, dated 6/29/25 05:00, includes in part: . Nursing description: Resident bed alarm sounding in room. As staff respond to alarm, staff hear a loud crash. Find resident on the floor, he had fallen into an old record cupboard along the wall on his roommate's side of the room. Resident lying on his left side, feet were toward the bed, head toward roommate side of room. [NAME] was at heater, facing the door. Seeming resident was walking toward the bathroom and had collapsed and went to the left of walker. [NAME] was left standing by itself. Resident was pale and diaphoretic (excessive sweating). Noted to have some slurred speech at the initial response time

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 1 residents (R20) reviewed for falls resulting in actual harm. R20 was self-transferring multiple times and on the eighth attempt, suffered an unwitnessed fall. The facility failed to provide temporary interventions to address the self-transferring. R20 was found to have a left acetabular (hip joint socket) fracture.This is evidenced by:Facility policy, titled Fall Prevention and Management Guidelines, reviewed and revised on 7/18/24, states in part; Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not because of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . When any resident experiences a fall, the facility will complete a post fall assessment and review: physical assessment with vital signs, neuro checks for any unwitnessed fall or witnessed fall where resident hits their head.alert MD of any abnormal findings from neuro checks - do not wait until series is completed to notify MD of abnormal findings.complete an incident report in Risk Management, notify physician and family/responsible party, review resident's care plan and update with any new interventions put in place to try to prevent additional falls, document all assessments and actions, obtain witness statements from other staff with possible knowledge or relevant information.R20 admitted to the facility initially on 10/14/24 and has diagnoses that include: paroxysmal atrial fibrillation (irregular rapid heart rate), unspecified fracture of left acetabulum (hip joint socket), acute kidney failure, hypothyroidism, benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland that can cause urination difficulty), and other obstructive and reflux uropathy (abnormality of the urinary tract).R20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/20/25, indicates R20's cognition is severely impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Section GG of this assessment indicates R20 needed substantial/maximum assist for toileting, going from sit to stand, and supervision or touching assist for walking.R20's Comprehensive Care Plan states in part: .Focus: At risk for falls . Interventions/Tasks: Bed in low position, date initiated: 10/14/24 . Broda chair by bedside when in bed, date initiated: 7/1/25 .Chair and bed alarms placed and check for proper functioning and placement every shift, date initiated: 5/2/25 .Encourage to transfer and change positions slowly, date initiated: 10/14/24 .FALL RISK (FYI), date initiated: 7/1/25 .Have commonly used articles within easy reach, date initiated: 10/14/24 . Reinforce need to call for assistance, date initiated: 10/14/24 .Reinforce w/c (wheelchair) safety as needed such as locking brakes, date initiated: 10/14/24 .Focus: Urinary Incontinence .Intervention/Tasks: Offer toileting every 2 hours and PRN, date initiated 1/26/25 .R20's Fall/Risk Management Report titled Unwitnessed Fall, dated 6/29/25 05:00 (5:00 AM), includes in part: . Nursing description: Resident bed alarm sounding in room. As staff respond to alarm, staff hear a loud crash. Find resident on the floor, he had fallen into an old record cupboard along the wall on his roommate's side of the room. Resident lying on his left side, feet were toward the bed, head toward roommate side of room. [NAME] was at heater, facing the door. Seeming resident was walking toward the bathroom and had collapsed and went to the left of walker. [NAME] was left standing by itself. Resident was pale and diaphoretic. Noted to have some slurred speech at the initial response time. Quick stroke assessment was negative. Tongue came out straight, equal hand grip strength. Resident complaining of pain to left elbow and left shoulder at this time. Resident description: Resident states that he was going to the bathroom. However resident has made the walk multiple times this shift to the bathroom and knows where to go, even in the dark. Resident was walking in the opposite direction at the time of his fall.Immediate Action Taken, Description: Resident VS (vital signs) taken immediately. Stroke assessment completed. Rapid trauma assessment completed. No complaints of pain to chest/ribs, abdomen or hips. No external/internal rotation to feet, no limb shortening of lower extremities present. Resident assisted to the bed with 3 staff members. Skin assessment completed. Skin tear unable to be approximated, wound covered with ABD and wrapped with kerlix at this time. Resident taken to Hospital? No.It is important to note the nurse who prepared this report and conducted the assessments is a Licensed Practical Nurse (LPN) (LPN H) and R20 was moved without an RN assessment. It's also important to note there is no mention of LPN H doing a range of motion assessment to the upper and lower extremities prior to

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:2Number of residents cited:1Based on interview and record review the facility failed to maintain acceptable parameters of nutritional status and consult with the residents Physician on this for 1 of 2 residents (R4) reviewed for nutrition of a total sample of 13 residents. R4 had a severe weight loss of 11. 29% in 6 months. The facility did not put interventions into place to prevent weight loss or update the physician during the 6-month period. Evidenced by:The facility policy entitled Weight Monitoring, dated 12/21/22, states, in part: . Policy: The interdisciplinary team will strive to prevent, monitor, and intervene for undesirable weight change for our residents.Procedure:Weight Assessment.7. The dietician will review the monthly weights to follow individual weight trends over time. Weight trends will be evaluated by the interdisciplinary team whether or not the criteria for significant weight change have been met.8. The threshold for significant weight change will be based on the following criteria [where percentage of body weight change= (usual weight-actual weight) / (usual weight) x 100]: a. 1 month- 5% weight change is significant; greater than 5% is severe. b. 3 months- 7.5% weight change is significant; greater than 7.5% is severe. c. 6 months- 10% weight change is significant; greater than 10% is severe.10. The nursing staff will notify the individual or responsible party, physician and RDN (registered dietician) or designee of any individual with an unintended significant weight change. Care Planning: .2. Individualized care plans shall address to the extent possible: a. The identified causes of weight change; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment.Interventions:1. Interventions for undesirable weight change shall be based on careful considerations of the following: .b. Nutrition and hydration needs of the resident. R4 admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (a condition where the body doesn't produce enough insulin or can't properly use the insulin it makes, leading to high blood sugar levels causing kidney damage), epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures) and mild intellectual disabilities (deficits in intellectual functions pertaining to abstract/theoretical thinking). R4's Care Plan, dated 4/11/23, states, in part: . Focus: At risk for nutritional status change related to Type DM (diabetes mellitus), CKD (chronic kidney disease), hyperkalemia, GERD, history of weight loss, diuretic use. Date Initiated: 4/11/23Goal: Will maintain weight as evidenced by no significant weight changes (>/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days).Date Initiated: 4/11/23. Revision on: 6/06/2025. Target Date: 9/02/2025.Interventions/Tasks: .-Eating- assist of 1 Date Initiated: 6/04/2025. Revision on: 6/04/2025.-Provide diet as ordered: Renal diet, L2/Mech Alt texture (level 2), Regular/Thin consistency, Low potassium. Date initiated: 4/11/2023. Revision on: 6/04/2025. R4's weights per facility record are as follows:*7/15/25- 154 (7# (pound) loss from previous month, 19.6# loss 6 months, 11.29% loss in 6 months)*6/17/25- 161 (5# loss from previous month)*5/13/25- 156*4/01/25- 155 (17# loss from previous month)*3/01/25- 172*2/14/25- 169 (4.6# loss from previous month)*1/01/25- 173.6 R4's Physician's Orders dated 7/17/25 include:-Renal diet L2/Mech Alt texture, Regular/Thin consistency, for ground meat Low Potassium Diet, at least 64 ounces of fluid per day Diet type: Renal for renal. Order Date: 5/20/2025.-Weight-(weekly) (Obtain re-weight if change of 5 lbs. since last weight) one time a day every Tuesday. Order Date: 4/29/2025. R4's Progress Note dated 4/08/25, at 11:21 AM, states, in part: . Writer reviewed weights. Will send recommendation. R4's Progress Note dated 4/29/25 at 10:03 AM, states, in part: . Average meal intake x 7 days = 75%-100% with occasional meals in 0-75% range and 2 meals refused per charting. Will send recommendations.R4's Progress Note dated 5/28/25, 2:47PM, states, in part: . Note Text: WEIGHT WARNINGValue: 159.0.-7.5% change [7.6%, 13.0]Weight has remained stable the past month with minor fluctuation. Meal intakes average >75% with occasional intakes <50% noted. Due to stabilization of weight recommend to continue current nutrition POC. R4's Progress Notes dated 7/09/25 2:04PM, states, in part: Type: Weight NoteNote Text: WEIGHT WARNINGValue: 155.0.MDS (Material Data Set): -10.0% change over 180 days [11.9%,21.0]Wt. (weight) Hx. (history)- 1 month ago: 157#, 3 months ago: 155#, 6 months ago: 176# BMI (body mass index) 25; 6# weight loss noted in the past month. Meal intakes average >51% with occasional intakes <51% noted and refusals occasionally.Due to stabilization of weight will continue current nutrition POC (Plan of Care) .On 7/17/25 at 10:15 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor reviewed with DON B R4's weights of 154# on 7/15/25, 161# on 6/17/25, 156# on 5/13/25, 155# on 4/1/25, 172# on 3/1/25, 169# on 2/14/25 and 173.6 on 1/1/25. Surveyor asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525622	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soldiers Grove Health Services	101 Sunshine Blvd Soldiers Grove, WI 54655

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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 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. Number of residents sampled:34Number of residents cited:34Based on record review and interview, 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 34 residents who reside in the facility.The facility's dishwasher was not reaching appropriate temperatures.Findings includeThe facility employs a high temperature dishwasher to clean and sanitize its dishware.The facility's policy, titled Warewashing, states, in part, All dishware, service ware, and utensils will be cleaned and sanitized after each use.the dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware.all dish machine water temperatures will be maintained in accordance with manufacture recommendations for high temperature or low temperature machines.temperature and/or sanitizer concentration logs will be completed, as appropriate.The facility's dish machine log indicates on the bottom of the form that the wash temperature is to be 150-165 degrees Fahrenheit, and the rinse temperature is to be between 180 and 194 degrees Fahrenheit. The form is filled out three times per day, as indicated by Breakfast, Lunch, Dinner. Each time/meal, temperatures for the wash, rinse and a non-regressing thermometer are all gathered.The posted dish machine log near the dishwasher for the month of July 2025 indicates the rinse temperature did not reach 180 degrees Fahrenheit 7 times from July 1, 2025 through July 17, 2025. Additionally, the non-regressing thermometer reading did not reach 160 degrees Fahrenheit on 19 occasions.On 7/17/2025 at 1:49 PM, Surveyor interviewed DM C (Dietary Manager) who indicated that the non-regressing thermometer reading is supposed to reach at least 160 degrees Fahrenheit. DM C stated that she has not been notified of any temperatures that did not reach 180 degrees Fahrenheit for the rinse or 160 degrees Fahrenheit for the non-regressing thermometer. DM C stated that if staff had not reached the necessary temperature, they should have run the dishwasher again and if repeated attempts did not reach the necessary temperatures, she should have been notified.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Number of residents sampled:34Number of residents cited:34Based on interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect the census of 34 residents. The facility has not established a line list that reflects resident's symptoms, lab results, symptom onset date, and the type of infection a resident has. Evidenced by: The facility's policy titled Infection Surveillance dated 3/8/23 states in part .1. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. The facility's policy titled Infection Prevention and Control Program dated 7/23/24 states in part .3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and all other individuals providing services under a contractual arrangement based upon a facility assessment and accepted standards.c. The RNs (Registered Nurses) and LPNs (licensed Practical Nurses) participate in surveillance through assessments of residents and reporting changes in condition to the residents' physicians and management staff per protocol for notification in changes and the in- house reporting of communicable diseases and infections. On 7/16/25, Surveyor reviewed the facility's infection prevention and control program for the months of April, May, and June. Surveyor noted that the documentation provided did not contain a line list that monitors all residents that have signs and/or symptoms of an actual or potential infection. The facility provided Surveyor with an Infection Control Log that includes the resident's name, the antibiotic ordered and start date and end date. This log does not include residents' symptoms, lab results, imaging results, or whether or not the resident met criteria for an antibiotic. On 7/17/25 at 10:07 AM, Surveyor interviewed IP F (Infection Preventionist) and DON B (Director of Nursing). Surveyor asked IP F if they had a line list that monitors residents that show signs/ symptoms of an actual or potential infection or illness, IP F stated that they do not have one specific list but has many. IP F stated that there is documentation in the facility's EHR (Electronic Health Record) that is completed by the nurses. Surveyor asked IP F how they are tracking and trending residents' symptoms, IP F stated that he can pull it from all the of the lists and the information in the EHR. On 7/21/25 at 10:01 AM, Surveyor interviewed DON B. Surveyor asked DON B if she would expect the Infection Preventionist to be tracking signs and symptoms of actual or potential infections on the line list, DON B stated yes. It is important to note that no additional information was provided to Surveyor regarding resident surveillance.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:7Number of residents cited:3Based on interview and record review, the facility does not follow a nationally recognized standard of practice for infection control or monitoring antibiotic use, and they do not have protocols in place to obtain cultures and other reports to ensure residents are receiving the correct antibiotic for 2 of 7 residents (R30 and R25) reviewed for infections. R30 was started on an antibiotic and had no documented signs of an infection. R25 received orders for a UA (Urinalysis) without meeting criteria and was subsequently placed on an antibiotic. Evidenced by: The facility's policy titled Antibiotic Stewardship Program revised on 11/18/22 states in part .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: i. Nursing staff shall assess/ gather data on residents who are suspected to have an infection and notify the physician. Documentation shall include the assessment or data gathered and the physician notification. ii. Laboratory testing shall be in accordance with current standards of practice. v. Prescriptions for antibiotics shall specify the dose, duration, and indication for use.b. Monitoring antibiotic use: .ii. Antibiotic orders obtained on admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness.iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. Example 1R30 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), diabetes insipidus (a disease that causes the body to make large amounts of urine and can lead to extreme thirst- occurs when fluid levels in the body are thrown out of balance), and general anxiety disorder. The facility form titled Criteria for Infection Report Form- Urinary Tract Infections (UTIS) dated 6/28/25 lists the following criteria: Resident exhibits: Fever (>100 degrees F (Fahrenheit) or 2.4 degrees above baseline or 2 or more instances in the past 12 hrs (hours) AND 2 or more symptoms not related to urinary tract infection (i.e. respiratory s/s (signs/ symptoms, GI (Gastro-intestinal), skin symptoms, etc.). If YES- Urine culture is NOT indicated, if NO- proceed to urinary symptom check. Urinary Symptom Check: Fever (>100 degrees F (Fahrenheit) or 2.4 degrees above baseline or 2 or more instances in the past 12 hrs (hours) AND 1 or more: Dysuria (pain or burning during urination), Urgency, Frequency, Suprapubic pain (lower abdomen pain), Gross Hematuria (blood in urine), Flank pain, Urinary Incontinence, Shaking Chills. If YES- Meets Criteria to order urine culture, if NO- Does not meet criteria. Results of Urine Culture: >105 CFU/ml (Colony forming units per milliliter) (positive) or pending urine culture AND dysuria. If YES- Meets criteria for antibiotic per physician order, if NO- Does not meet criteria. Or if resident experiences 2 or more of the following: Fever (>100 degrees F (Fahrenheit) or 2.4 degrees above baseline or 2 or more instances in the past 12 hrs (hours), Urgency (new or worsening), Suprapubic pain, Gross hematuria, flank pain, urinary incontinence, shaking/ Chills. If YES- Meets criteria for antibiotic per physician criteria, if NO- does not meet criteria. R30's form does not have any criteria marked, but states Klebsiella in the comments. R30's urine culture results received on 6/28/25 states: Culture- Urine Colony count = >100,000 cfu/ml Klebsiella oxytoca. It is important to note, that according to the facility's form, R30 does not meet the criteria for an antibiotic. On 6/30/25, R30 was started on Nitrofurantoin Macrocrystal Capsule 100mg one time a day for 7 days. On 7/17/25 at 10:07 AM, Surveyor interviewed IP F (Infection Preventionist) and DON B (Director of Nursing). Surveyor asked IP F what R30's symptoms were and if R30 met criteria for a UA (Urinalysis) and an antibiotic, IP F stated that R30 did not have any symptoms, and that the UA was obtained at a doctor's appointment. Surveyor asked IP F if R30 met criteria for an antibiotic, IP F stated that he thought R30 met criteria by testing positive for Klebsiella. Surveyor asked IP F and DON B if the provider was updated regarding R30 being asymptomatic and not meeting the colony count for an antibiotic, DON B stated no, and the provider should have been updated. Example 2: R25 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, major depressive disorder, and weakness. The facility form titled Criteria for Infection Report Form- Urinary Tract Infections (UTIS) dated 4/19/25/25 lists the following criteria: Resident exhibits: Fever (>100 degrees F (Fahrenheit) or 2.4 degrees above baseline or 2 or more instances in the past 12 hrs (hours) AND 2 or more symptoms not related to urinary tract infection (i.e. respiratory s/s (signs/ symptoms, GI (Gastro- intestinal), skin symptoms, etc.). If YES- Urine culture is NOT indicated, if NO- proceed to urinary symptom check. Urinary Symptom Check: Fever (>100 degrees F (Fahrenheit) or 2.4 degrees above baseline or 2 or more instances in the past 12 hrs (hours) AND 1 or more: Dysuria (pain or burning during urination), Urgency