STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525209	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulder Health Care Facility	713 Leonard St N West Salem, WI 54669

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observation, interview and record review, the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene for 1 of 22 residents reviewed for ADLs (Activities of Daily Living) (R34). R34 requested to use the bathroom. CNA EEE (Certified Nursing Assistant) told R34 she is on a two (2) hour toileting schedule and will need to wait. R34 was waiting approximately 1 hour and 20 minutes before being assisted to the bathroom. Evidenced by: The facility's policy, Activities of Daily Living, dated 3/2023, includes, in part, as follows: It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. The facility will provide care and services for the following activities .Elimination-toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming and personal hygiene . R34 was admitted to the facility 10/18/24 with diagnoses including, but not limited to, need for assistance with personal care, encounter for orthopedic aftercare following surgical amputation, acquired absence of left foot, and osteoarthritis of knee. R34's MDS (Minimum Data Set) assessment dated [DATE] notes a Brief Interview of Mental Status score of 13/15 indicating R34 is cognitively intact. R34 requires extensive assist of 2 staff for toileting. R34 is her own decision maker. R34's comprehensive care plan documents, in part, as follows: (Problem Start Date: 10/29/24) Urinary Incontinence: Resident is occasionally incontinent of bladder. Continent of bowel. Uses bedpan or commode. Long Term Goal Target Date 5/1/25 Resident will be clean, dry and odor free. Approach: .(Approach Start Date: 10/29/24) Provide staff assistance for all toileting and incontinence needs. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's comprehensive care plan documents, in part, as follows: Resident at risk for falls related to recent surgery/amputation of partial right foot, general weakness. Goal: Resident will be free from falls and injury due to fall. Approach: (Approach Start Date: 10/29/24) Resident is NWB (non weight bearing)to right leg, Hoyer lift (full body), assist of 2. On 4/7/25 at 10:35 AM, Surveyor spoke with R34. R34 stated, about 15 minutes ago she asked CNA EEE (Certified Nursing Assistant) for assistance to use the bathroom. R34 stated, CNA EEE, told her she was on a two (2) hour toileting schedule and would need to wait. Surveyor asked R34, how did this make you feel. R34 stated, There ain't nothing I can do about it if I have to wait. R34 added, I didn't know I was on a 2 hour toileting schedule again. Note, R34 is not a two (2) hour toileting schedule. On 4/07/25 at 10:37 AM, Surveyor spoke with CNA EEE (Certified Nursing Assistant). Surveyor asked CNA EEE, how long she has been working at the facility. CNA EEE stated, two (2) years. Surveyor asked CNA EEE, is R34 on a two (2) hour toileting schedule. CNA EEE stated, yes, from what she has been told. Surveyor asked, CNA EEE, when R34 asked her to use the bathroom about 15 minutes prior, what did she tell R34. CNA EEE stated, I told her she's on a toileting schedule and I need to take care of other residents first. Surveyor asked CNA EEE, what should you do when a resident is on a toileting schedule and asks to use bathroom in between the two (2) hour window. CNA EEE stated, Probably take them right away. CNA EEE stated, CNA JJ (Certified Nursing Assistant) is on break and she needs to wait for him. On 4/7/25 at 10:42 AM, Surveyor observed CNA JJ (Certified Nursing Assistant) come to R34's room. Surveyor observed CNA JJ state to CNA EEE, R34 is not in her room did she go to the activity. On 4/7/25 at 10:56 AM, Surveyor spoke with CNA JJ (Certified Nursing Assistant). Surveyor asked CNA JJ, how long he has worked at the facility. CNA JJ stated, he has worked at the facility for 1 1/2 years. Surveyor asked CNA JJ, is R34 on a two (2) hour toileting schedule. CNA JJ stated, he honestly has no idea and some staff say they take R34 to the bathroom when she requests. CNA JJ stated, when he sees her call light on he takes her to the bathroom. CNA JJ stated, R34 declined when he followed up with her. Surveyor asked CNA JJ, when did you asked R34. CNA JJ stated, around 10:45 AM. Note, Surveyor observed CNA JJ filling water mugs, however, CNA JJ did not follow up with R34 while she was in the activity as Surveyor was observing during the time R34 was in the activity. On 4/7/25 from 10:35 AM - 11:30 AM, Surveyor observed R34 in an activity. Surveyor observed that no staff approached R34 to ask if she needs to use the bathroom. On 4/7/25 at 11:30 AM, Surveyor observed R34 enter her room and activate her call light. On 4/7/25 at 11:30 AM, Surveyor asked R34, did any staff ask if you needed to use the bathroom since you went to the activity. R34 stated, no. On 4/7/25 at 11:38 AM, Surveyor observed CNA EEE and CNA JJ enter R34's room and assist her to the bathroom. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 3:45 PM, Surveyor spoke with R34. Surveyor asked R34, how did being told she needed to wait two (2) hours in between toileting and staff would not assisting her make her feel. R34 stated, she did not want to go in her pants. R34 added, she can't remember if she had an accident. On 4/10/25 at 1:20 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, if a resident requests to be toileted what do you expect staff to do. DON B stated, staff should respond to the need ASAP (As Soon As Possible). Surveyor asked DON B, what if a resident is on a two (2) hour toileting schedule. DON B stated, same answer, as soon as they have time to respond to whatever need is requested by the resident. Surveyor asked DON B, what is a reasonable amount of time for a resident to wait for assistance to use the bathroom. DON B stated, the call light average is 7-10 minutes at the absolute most. Surveyor stated, on 4/7/25 at approximately 10:15-10:20 AM, R34 asked CNA EEE to use the bathroom. Surveyor stated, R34 waited approximately 1 hour and 20 minutes. Surveyor asked DON B, is this an acceptable amount of time for a resident to wait to be toileted. DON B stated, no. Surveyor asked DON B, what should CNA EEE have done. DON B stated, CNA EEE should find any other staff member (to assist). Surveyor asked DON B, what should CNA JJ (Certified Nursing Assistant) have done. DON B stated, CNA JJ should have checked in with R34 to see if she needed to use the bathroom. DON B stated, R34 prefers to not have CNA JJ care for her but she has allowed him to perform cares. DON B added, at that time if she did not allow CNA JJ to assist her CNA JJ should have found other staff. Surveyor asked DON B, should staff have approached R34 during the activity and discreetly asked if she needed to use the bathroom. DON B stated, yes, staff should have asked R34. Surveyor asked DON B, is R34 on a two (2) hour toileting schedule. DON B stated, not that she is aware. R34 requested to use the bathroom. CNA EEE told R34 she is on a two (2) hour toileting schedule and will need to wait. R34 was waiting approximately 1 hour and 20 minutes before being assisted to the bathroom.

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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 - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observation, interview, and record review, the facility failed to ensure residents received adequate fluid intake to maintain acceptable parameters of hydration for 1 of 4 Residents (R19) reviewed for nutrition. On 3/7 - 3/13/25 R19 was hospitalized with aspiration pneumonia and received intravenous fluids during his hospitalization . On 3/17-3/19/25 R19 was hospitalized with dehydration requiring intravenous fluids. R19 was consistently not meeting his daily recommended fluid intake of greater than 1,400 ml (milliliters). R19 had a significant weight loss of 10.9% from 3/7/25 - 3/26/25. The facility failed to ensure R19 received adequate fluid intakes to maintain acceptable parameters of hydration by failing to total and assess daily fluid intake; accurately assess and complete on going assessments for signs and symptoms of dehydration (e.g., sunken eyes, cool/clammy skin, dry tongue, dark colored urine, and sticky saliva); failure to weigh resident weekly; failure to weigh resident upon readmission to the facility; failure to add/revise care plan interventions to prevent further dehydration and weight loss; failure to timely communicate weight changes to provider. This is evidenced by: Facility Policy entitled 'Dehydration/Fluid Maintenance, reviewed 1/2025, states in part: Purpose: To determine the risk status of residents to develop dehydration and to implement measures to assure adequate fluid/maintenance hydration. Goal: To prevent dehydration from happening by identifying risk factors which lead to dehydration and provide the resident with sufficient fluid intake to maintain proper hydration and health. Procedure: At the time of each resident's admission, readmission, quarterly review, or significant change in condition, a Nutritional Assessment will be completed by the DTR/RD with input from the interdisciplinary team. The attending physician will be notified of the results of the assessment if the resident is found to be at risk for dehydration and the appropriate recommendations will be written and protocols will be implemented to promote hydration. Risk factors include: a. Fluid loss exceeds the amount of fluids consumed, b. Elevated temperatures or infection, c. Dependence on staff for the provision of fluid intake, e. Renal disease, f. Dysphagia, g. Limited fluid intake lacking thirst sensation, h. Refusal of fluids. Once risk factors are identified, a plan of care will be initiated to provide sufficient fluid and maintain proper hydration. Plan for the amount of fluid provided at each meal, snack and additional fluids provided by nursing staff. Based on medical condition, ability to consume adequate fluids, and/or any resident that presents with a diagnosis of dehydration will have a care plan that addresses the potential for dehydration/fluid maintenance. Assessing and Care Planning: Follow the standard care process of identification, assessment, treatment and monitoring when addressing dehydration. Interventions should be individualized, aggressive, and revised as needed based on the residents responses, outcome and needs. Creative Suggestions include: (consider using to keep residents well hydrated) Offer additional fluids during medication time (4-8 ounces), Assist residents to drink fluids, Ensure that clients received thickened liquids are encouraged to consume adequate fluids due to their high risk of dehydration. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	According to Strategies for Ensuring Good Hydration in the Elderly, Dehydration is a frequent etiology of morbidity and mortality in elderly people. It causes the hospitalization of many patients and its outcome may be fatal. Indeed, dehydration is often linked to infection, and if it is overlooked, mortality may be over 50%. Older individuals have been shown to have a higher risk of developing dehydration than younger adults. Modifications in water metabolism with aging and fluid imbalance in the frail elderly are the main factors to consider in the prevention of dehydration. Particularly, a decrease in the fat free mass, which is hydrated and contains 73% water, is observed in the elderly due to losses in muscular mass, total body water, and bone mass. Since water intake is mainly stimulated by thirst, and since the thirst sensation decreases with aging, risk factors for dehydration are those that lead to a loss of autonomy or a loss of cognitive function that limit the access to beverages. The prevention of dehydration must be multidisciplinary. Caregivers and health care professionals should be constantly aware of the risk factors and signs of dehydration in elderly patients. Strategies to maintain normal hydration should comprise practical approaches to induce the elderly to drink enough. This can be accomplished by frequent encouragement to drink, by offering a wide variety of beverages, by advising to drink often rather than large amounts, and by adaptation of the environment and medications as necessary. https://onlinelibrary.[NAME].com/doi/pdf/10.1111/j.1753-4887.2005.tb00151.x The facility policy, Weight and Height Records Policy, revised 8/2023, documents, in part, as follows: In order to provide appropriate and resident centered care the facility staff will obtain and monitor resident weights as follows: Weight loss or gain of 3# (pounds) less for those residents 100# will resident in a resident being reweighed. Weights greater than 100# will follow weight bariance [sic] reporting for CMS/MDS (Centers for Medicare and Medicaid Services/Minimum Data Set) guidelines as follows: 5% +/-30 days, 7.5% +/-90 days, 10% +/-180 days. Weights will be recorded in EMR (electronic medical record) when obtained. Dietician/CDM (Certified Dietary Manager) weight range will not exceed +/-10% (percent). R19 was admitted to the facility on [DATE] with diagnoses including, but not limited to, as follows: multiple sclerosis (a central nervous system condition that disrupts communication between the brain and body), chronic kidney disease stage 3 (a moderate decline in kidney function), weakness, and dysphagia oropharyngeal phase (difficulty with the oral prepatory phase - trouble forming the food bolus before swallowing). On 3/27/24 RD G (Registered Dietician) completed the following Initial Assessment: Diet Fluids >1,400 ml/day (greater than 1,400 milliliters per day) On 9/27/24 DON B (Director of Nursing) ordered the following for R19: Weekly weight. Once a day on Monday R19 is a DNR (Do Not Resuscitate). It is noted in R19's record, R19's APOAHC (Activated Power of Attorney for Health Care) made the decision to enroll R19 in comfort care on 3/28/25. Of note, R19's APOAHC declined hospice care. R19's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R19 has a Brief interview of Mental Status (BIMS) of 10 out of 15 indicating he is moderately cognitively impaired. R19's family member is his APOAHC (Activated Power of Attorney for Health Care). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R19's comprehensive care plan documents, in part, as follows: (Problem Start Date: 3/19/25) R19 is at end of life, is receiving comfort care. (Approach start date: 3/28/25) R19's APOAHC (Activated Power of Attorney for Health Care) declined hospice services stating she would only like the facility staff to care for him and no other staff. R19's comprehensive care plan documents, in part as follows: (Problem Start Date: 4/7/23) Nutritional Status-Resident triggers at risk for malnutrition based on MNA (mini nutritional assessment), PMH (past medical history), mechanically altered diet textures, and disease progression. Goal: Resident will receive adequate nutrition/hydration. Approach: .(Approach Start Date: 4/7/23) Diet provides >1,920 cc's of fluids per day. Encourage nectar thick fluids at bedside and with activities. Monitor for signs & symptoms of fluid imbalance (i.e. swelling, shortness of breath, dry mucous membranes, dry skin, poor skin turgor). Monitor meal intake/record. Offer substitutes if consumes <50% of meals. On 1/20/25 R19 weighed 204.1 On 1/27/25 R19 weighed 202.9 On 2/10/25 R19 weighed 203.1 It is important to note, the facility is collecting intakes, however, the facility is not totaling R19's daily fluid intakes, therefore not assessing the data they are collecting. R19's intakes (calculated by Surveyor) leading up to hospitalization are as follows: 3/3: 200 ml 3/4: 900 ml 3/5: 400 ml 3/6: 800 ml Of note, R19 did not reach his fluids needs. On 3/6/25 the Nurse Practitioner wrote the following order: Encourage fluids/hydration throughout the shift. 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM R19 was hospitalized [DATE] -3/13/25 for aspiration pneumonia. R19 received IV (intravenous) fluids during this hospitalization . *See RD G's (Registered Dietician) note below. On 3/13/25 at 4:04 PM, RD G (Registered Dietician) documented the following Progress Note: Nutrition Update: Noted resident's return from the hospital following sepsis. Received IVF (intravenous fluids) d/t (due to) hydration needs. *Received an estimated total of 5,124 ml between 3/7-3/8, with an average of 731 ml per day over 7 days. Current diet order in place: Pureed with nectar thick liquids. Continue to monitor chewing/swallowing ability at this facility, SLP (Speech-Language Pathology) to eval (evaluate) in-house, RD G will continue to monitor and f/u (follow up) quarterly/prn (as needed) to assess intake, wt (weight) status, and diet tolerance. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R19's intakes (calculated by Surveyor) leading up to hospitalization are as follows: 3/13: 320 ml 3/14: 580 ml 3/15: 370 ml 3/16: 680 ml Of note, R19 did not reach his fluids needs, the facility did not provide documentation of a dehydration assessment. The facility did not weigh R19 from 3/13 - 3/17/25. R19 was hospitalized ,d+[DATE]-[DATE] with dehydration requiring IV (intravenous) fluids. R19's hospital report documents, in part, as follows: Creatinine: 2.28 (High). Estimate GFR: 29 (High) Sodium: 144 (Reference Range 135-145) The hospital physician documents, in part, as follows: Patient was admitted to inpatient on 3/17/25 for Somnolence (excess sleepiness). admitted for infection vs dehydration causing AMS (Altered Mental Status) - appeared hemoconcentrated (increase in red blood cells, white blood cells and platelets in the blood due to a reduction in the volume of plasma (liquid portion of the blood).), high specific gravity. Urine and blood cultures negative at 24 hours, abx (antibiotics) discontinued. Patient continued to do well. Returned to baseline mentation after fluid administration - *feel this was dehydration with lack of infectious etiologies. The hospital has the following weights documented for R19: 3/7/25: 218.4 3/17/25: 208.3 - It is important to note, R19 lost over ten (10) pounds in 10 days. (Significant weight loss) = -4.62% 3/18/25: 206.1 = - 5.63% 3/19/25: 207.8 = -4.85% On 3/19/25 R19 was readmitted to the facility following a hospital stay. The facility did not obtain R19's weight upon readmission. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/20/25 at 3:05 PM, RD G (Registered Dietician) documented the following Progress Note: Nutrition Update: Noted resident's return from the hospital following an event of somnolence. Received IVF (intravenous fluids) d/t hydration needs. *Received an estimated total of 5,800 ml (milliliters) between 3/17-3/18/25, with an average of 834 ml per day over 7 days. Current diet order in place: Pureed with nectar thick liquids. Continue to monitoring chewing/swallowing ability at this facility, SLP (Speech-Language Pathology) to eval (evaluate) in-house. RD G will continue to monitor and f/u (follow up) quarterly/prn (as needed) to assess intake, wt (weight) status, and diet tolerance. (Of note: R19 has received over 10,000ml of IV fluids during hospitalization in less than 2 weeks.) On 3/26/25 R19 weighed 194.6 at the facility there is no documentation indicating R19's Physician/provider was updated. (It is important to note, R19 returned to the facility following a hospitalization on [DATE]. The facility did not weigh R19 until 3/26/25. During this time, R19 continued to lose weight.) From 3/19/25 - 3/26/25 R19 experienced a 6.35% weight loss. On 3/27/25 at 4:28 PM, RD G (Registered Dietician) documented the following Progress Note: Nutrition update: Noted resident's updated weight status, and 195 lbs (pounds) on 3/26/25. 9 lb loss over the past 1.5 months. The loss was anticipated r/t (related to) multiple hospitalization s within this timeframe. Continue to monitor wt (weight) status for goal of stabilization. Continue current diet textures and feeding precautions in place. RD G will continue to monitor and f/u (follow up) prn (as needed). Of note, there is no documentation of any weights/monitoring until eight (8) days after R19's readmission to the facility. There are no new care plan interventions indicated as being implemented upon R19's return after being hospitalized related to dehydration. No documentation was provided indicating nurses are monitoring or documenting signs and symptoms for R19 related to dehydration. On 4/7/25 R19 weighed 200 .9 On 4/14/25 at approximately 12:00 PM, Surveyor observed CNA CCC (Certified Nursing Assistant) assisting R19 with his lunch in the dining room. Surveyor observed R19 had ample fluids and food on his tray for the meal. R19 had 480 ml (milliliters) of fluid on his tray. Surveyor observed R19 drank 240 ml. On 4/14/25 at 1:00 PM, Surveyor spoke with RN DDD (Registered Nurse). Surveyor asked RN DDD, who documents fluid intakes. RN DDD stated, the nurses document fluid intakes at the end of the shift. RN DDD stated, nurses and CNA's (Certified Nursing Assistants) document in the same place. Surveyor asked RN DDD, who is responsible for totaling daily fluid intakes. RN DDD stated, she is unsure and the computer system may automatically. Surveyor asked RN DDD, what are symptoms of dehydration that require monitoring. RN DDD stated, staff should monitor output, skin turgor, dry lips, low blood pressure, etc. RN DDD stated, staff really have to be on top of offering R19 fluids while he is in his room. RN DDD stated, R19 needs assistance with eating and drinking and he has end stage MS (Multiple Sclerosis), a degenerative disease. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/14/25 at 1:40 PM, Surveyor spoke with CNA CCC (Certified Nursing Assistant). Surveyor asked CNA CCC (Certified Nursing Assistant) if R19 has difficulty eating or drinking. CNA CCC stated, sometimes R19 gets too sleepy so she will take a break or ask if R19 is finished. CNA CCC stated, R19 has better days than others. CNA CCC stated, sometimes R19 will hold food in his mouth and she will follow up and offer him juice to help get the food down. CNA CCC stated, R19 does not normally have any difficulty swallowing liquids. Surveyor asked CNA CCC, do you record fluid intakes for R19. CNA CCC stated, she records intakes or tells the CNA's what R19 ate or drank. CNA CCC stated, R19 had 480 milliliters of fluids on his tray and R19 drank 240 ml (milliliters) between nectar thick milk and orange juice at lunch today. CNA CCC stated, R19 was unable to finish the meal as he got too sleepy to finish the rest. CNA CCC stated, R19 would drop his head down. CNA CCC stated, R19 has fluids in his room such as apple juice (out of reach for safety reasons) that staff will offer R19 and give him a couple sips. On 4/14/25 at 2:00 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, is she aware that R19 was dehydrated during the 3/17-3/19/25 hospitalization . DON B stated, she does not remember if the facility has that documented or not. Surveyor shared RD G's (Registered Dietician) Progress Notes (above). DON B stated, yes, the facility is aware. Surveyor asked DON B, are you aware that R19's received IVF (intravenous fluids) during his prior hospitalization from ,d+[DATE]-[DATE]. DON B stated, yes, she is aware of that. Surveyor asked DON B, what is the facility doing to address this. DON B stated, R19 has an order in place to encourage fluids. DON B stated, R19 is following up with ST (Speech Therapy) & OT (Occupational Therapy). DON B stated, R19 is currently actively participating in ST and OT. Surveyor asked DON B, who is responsible for totaling R19's daily fluid intakes. DON B stated, she is unsure. DON B added, RD G may calculate the fluid totals. (Note, per interview with RD G (below), she does not calculate fluid totals on a daily basis. Currently, nobody at the facility totals daily fluid intakes. Subsequently, daily fluid intakes are not being monitored on a daily basis.) Surveyor asked DON B, how do you know that R19 is meeting his daily fluid needs when his fluid intakes are not totaled on a daily basis. DON B stated, there's no way to know if R19 is meeting his daily fluid needs. DON B stated, staff would need to add the fluid totals. Surveyor asked DON B, would you expect staff to total fluid intakes. DON B stated, yes. Surveyor asked DON B, why is this important. DON B stated to make sure R19 is adequately hydrated. DON B stated, we did recently have a goal of cares switched from Full Code to DNR (Do Not Resuscitate) due to weight loss and overall decline. Surveyor asked DON B, when were intakes put in place for R19. DON B stated, this started on 10/14/24 to encourage fluids. Surveyor asked DON B, what was this in response to. DON B stated, this was to a high Creatinine lab. Surveyor asked DON B, are staff to be encouraging fluids. DON B stated, yes. Surveyor asked DON B, should R19 have fluid in his room. DON B stated, staff can bring fluids when they check in on him and offer. DON B stated staff should be assisting him with fluids and should leave them out of R19's reach as R19 requires supervision with drinking and eating. Surveyor asked DON B, should the provider have been notified with R19's significant weight loss. DON B stated, yes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525209	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulder Health Care Facility	713 Leonard St N West Salem, WI 54669

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 0692 Level of Harm - Actual harm Residents Affected - Few	On 4/14/25 at 2:19 PM, Surveyor spoke with RD G (Registered Dietician). Surveyor asked RD G, where do staff record fluid intakes. RD G stated, she believes staff document intakes under vital signs and that's where she looks for intakes. Surveyor asked RD G, do staff document fluid intakes in any other locations. RD G stated, no, not that she is aware. Surveyor asked RD G, who is responsible for totaling daily fluid intakes. RD G stated, that would be the nursing realm. RD G stated she looks at fluid intakes as a whole picture and does not total them on a daily basis. Surveyor asked RD G, why is important to ensure that residents are getting enough fluids and adequately hydrated. RD G stated, to ensure residents do not become dehydrated. RD G stated, for R19 the facility provides nectar thick fluids, Magic Cups (supplement), encourage milk, juice, and water with all meals. The facility failed to ensure R19 received adequate fluid intakes to maintain acceptable parameters of hydration