| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ingleside Manor | 407 N Eighth St<br>Mount Horeb, WI 53572 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on interview and record review, the facility did not ensure grievances and recommendations discussed during resident group meetings (Resident Council) were acted upon promptly, for 3 of 11 supplemental residents (R12, R46, R52) and 2 of 18 sampled residents (R26 & R42). During Resident Council Task, three months of Resident Council Minutes were reviewed to find 3 (R12, R46, R52) residents had voiced concerns regarding facility phone issues. R12 and R42 voiced concerns to Surveyors regarding concerns with no one answering the facility phone. Evidenced by: The facility policy entitled, Ingleside Manor Resident Council Policy and Procedure, dated 5/26/2021, states, in part: . Policy: It is the policy of this facility to support and assist in the formulation of a Resident Council which provides a formal, structured process for communication among residents, staff and administrator. Procedure: . *Within the Resident Council forum, provide the members with the opportunity to express their concerns, contribute ideas, and make recommendations regarding the facility's functions. *A request will be made for formal written responses to all identified concerns and a set deadline for a reply as prior to the next Council Meeting. Resident Council Minutes dated 7/02/2025 include: *R52 questioned if the facility has someone at the front desk to answer the phone. R52 voiced concern with having had an appointment and when appointment was over, she tried calling the facility because her ride back to the facility was not there to pick her up. R52 indicated she called the facility, and someone answered and hung up. R52 called back and no one answered. R52 indicated she called and left a voicemail with ANHA C (Assistant Nursing Home Administrator) and someone else. R52 indicated she was stuck at her appointment. Resident Council Minutes dated 8/08/25 include: *R46 voiced concern with people trying to call the facility and not being able to get a hold of anyone. R46 indicated she has sat up by the nurses' station and observed the phone ringing and no one answering it. On 10/1/25, at 10:05AM, Surveyor interviewed R46 who indicated when she has been out for appointments and has tried calling the facility no one has answered. R46 indicated when the nurse or doctor needed more information from the facility and has tried calling, they as well can't get through. *R12 indicated he has an issue he brought up with ANHA C; R12 had a friend trying to get ahold of him to notify R12 that a friend of theirs was passing. R12 indicated the friend called the facility many times and could not get ahold of R12. R12 indicated he voiced his concern to ANHA C that the phone issue needs to be figured out and someone must be answering the phones. R12 indicated he was told that the facility may get everyone a cell phone to carry on them. R12 voiced that the facility says they will work on these issues but R12 feels the facility does not care about the residents because they have done nothing with the issues. On 10/1/25, at 10:11AM, Surveyor interviewed R12. R12 indicated when he has gone out with family or friends, and he has tried calling the facility to let them know he is running late on getting back to the facility. No one has answered the phone. R12 indicates he is unable to update the facility and worries the facility will put a silver alert out on him. R12 indicates no one answers the phone and there is no way to get the facility a message. R12 indicated the whole<br><br>(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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | building is listed under the same number; when R12's girlfriend calls the facility she gets a busy signal or else the phone doesn't get answered. On 9/30/25, at 3:02PM, Surveyor interviewed R42 who voiced concern with the facility not answering the phone. R42 indicated this morning she had an appointment and could not get anyone to answer her call light, so she tried calling the facility and had gone right down the list of staff by number and no one was answering the phone. R42 indicated she finally got through to AN Q (Admissions Nurse). R42 indicated the phone does not get answered during off hours and the weekends. R42 indicated it scares her because if she can't get anyone to answer her call light or the phone what is she to do. R42 indicated she does not want to have to call 911 but will if she must. On 10/1/25, at 10:00AM, Surveyor interviewed R52 who indicated the facility does not man the phones. R52 indicated she had a problem with a doctor appointment, and she tried calling the facility and no one answered. R52 indicated she did not know who was picking her up from her doctor appointment and tried calling the facility to find out and no one would answer the phone. R52 tried three times then called her daughter. On 10/1/25, at 8:10AM, Surveyor interviewed R26. R26 indicated the facility does not answer the phone. R26 indicated he will call, and no one answers the phone. On 10/1/25, at 4:54PM, Surveyor interviewed ANHA C. Surveyor asked ANHA C if he was aware of issues with the phone not being answered. ANHA C indicated the receptionist had gone into early retirement that caused some gaps and CNAs (Certified Nursing Assistants) have filled in. ANHA C indicated there is a receptionist from 8am-8pm Monday through Friday. ANHA C indicated there are gaps with the recent retirement though and he was aware. ANHA C indicated on the weekends the phone rings to the receptionist and if it is not answered it bounces to the nurse stations. ANHA C indicated if a nurse is not sitting there at the nurse station, the call will go to voice mail. ANHA C indicated the nurses are expected to check voicemail throughout the shift. Surveyor asked ANHA C if he was aware of Resident Council concerns and ANHA C indicated yes, he reviews them monthly. ANHA C indicated he delegates the concerns to where he feels they need to go. Surveyor asked if ANHA C reviewed the July and August Resident Council Minutes regarding resident concerns with the facility phone not being answered. ANHA C indicated he did not see those minutes. ANHA C indicated the facility recently switched the answering system sound board because of the issues with calls not being transferred to people and people could not adequately use the dial by direct. Surveyor asked when this switch took place and ANHA C indicated July. ANHA C indicated he has boxes of phones to disperse to the nurses, he just has not dispersed them yet. Surveyor informed ANHA C that residents have voiced concerns to Surveyors about the phones not being answered while conducting the facility's annual survey. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the resident's right to request, refuse, and/or discontinue treatment and to formulate an advanced directive for 5 of 18 residents (R8, R7, R3, R26, R67) reviewed for advanced directives.<br><br>R8, R7, R3, R26, and R67's charts did not contain current copies of their advanced directive and/or did not contain evidence of advanced care planning, other than code status, for a time when they are not able to make their own healthcare decisions.<br><br>Evidenced by:<br><br>The facility's Advance Directives policy, dated 9/2022, states, in part: .Determining Existence of Advance Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.If the Resident Does not have an Advance Directive 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives.b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance.<br><br>Example 1<br><br>R8 admitted to the facility on [DATE].<br><br>On 9/24/25 at 12:22 PM, during the record review portion of the initial pool process, Surveyor was unable to find documentation of a Power of Attorney for Health Care (POAHC) for R8 or evidence of a discussion with R8 about establishing one.<br><br>Example 2<br><br>R7 admitted to the facility on [DATE].<br><br>On 9/24/25 at 3:03 PM, during the record review portion of the initial pool process, Surveyor was unable to find documentation of a POAHC for R7 or evidence of a discussion with R7 about establishing one.<br><br>On 9/30/25 at 9:02 AM, Surveyor interviewed ANHA C (Assistant Nursing Home Administrator) who indicated that the Social Services Director's last day of work was 9/25/25 and ANHA C was taking those responsibilities at present time. Surveyor asked about advanced directives. ANHA C stated that advanced directives are discussed at time of admission / admission care conference. If the resident hasn't shared POAHC documentation, the process is discussed, and the facility offers to help with the paperwork. Surveyor asked if this discussion is documented. ANHA C stated yes, there should be a progress note from the social worker. Surveyor asked if there was documentation of a POAHC or discussion about creating a POAHC for R7. ANHA C reviewed R7's chart and stated there was no document or note of discussion. ANHA C stated there should have been note of discussion and what decision was made by the resident. Surveyor asked if there was note of discussion for R8, R3, R26, and R67. ANHA C stated<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | that ANHA C would review charts.<br><br>On 9/30/25 at 9:50 AM, ANHA C stated there was no documentation of discussion of POAHC for R8, R3, R26, and R67 and that there should have been.<br><br>On 10/1/25 at 9:50 AM, Surveyor interviewed DON B (Director of Nursing) and asked about POAHC. DON B stated yes, there should absolutely be a documented conversation with the resident upon admission and facility should be assisting as needed.<br><br>Example 3:<br><br>R3 admitted to the facility on [DATE].<br><br>During the recertification survey, Surveyor was unable to locate documentation of a Power of Attorney for Health Care (POAHC) for R3 during record review. Surveyor could not find evidence of a discussion with R3 about establishing a POAHC.<br><br>Example 4:<br><br>R26 admitted to the facility on [DATE].<br><br>During the recertification survey, Surveyor was unable to locate documentation of a POAHC for R26 during record review. Surveyor could not find evidence of a discussion with R26 about establishing a POAHC.<br><br>Example 5:<br><br>R67 admitted to the facility on [DATE].<br><br>During the recertification survey, Surveyor was unable to locate documentation of a POAHC for R67 during record review. Surveyor could not find evidence of a discussion with R67 about establishing a POAHC. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident had the right to a safe, clean, comfortable, and homelike environment for 1 of 3 shower room affecting a pattern of residents who use the shower room and 1 (R67) of 19 sampled residents.<br><br>Surveyor observed the Whirlpool Shower Room (Note just shower) to not be homelike with the following visible repairs needed:<br><br>Example 1: Opening in floor covered by a loose piece of tile and a board laying over a large open area<br><br>Example 2: Tiles missing on the wall next to the shower with exposed rusty metal protruding from the wall<br><br>Example 3: Missing tiles on the shower floor<br><br>Example 4: Dark substance along the inside right where the shower wall meets the floor. Tiles are broken and worn in this area as well.<br><br>Example 5: Vent above shower coated with dust; dust is visibly hanging off the vent<br><br>Example 6: Hairband in shower drain in the tub for one (1) week without being picked up. The shower is not being cleaned.<br><br>R67's chair rail was in need of repair in R67's room presenting a safety hazard.<br><br>This is evidenced by:<br><br>The facility policy, Quality of Life – Homelike Environment, revised May 2017, states, in part: The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Clean, sanitary and orderly environment<br><br>On 10/1/25 at 7:45 AM, Surveyors requested ANHA C (Assistant Nursing Home Administrator) and MD E (Maintenance Director) to walk to the shower room with Surveyors.<br><br>Example 1: Opening in floor covered by a loose piece of tile and a board laying over a large open area<br><br>Surveyors asked MD E (Maintenance Director) to move the items so Surveyor could see what is located underneath the items. MD E picked up the items off the area to reveal a very large open hole with previously used plumbing. MD E stated, we need to fill this with gravel and concrete. Surveyor asked is this a hazard to residents. ANHA C (Assistant Nursing Home Administrator) stated, yes, it's not secure and carts or a Hoyer could get hooked or bump this with how easy we can lift these items up.<br><br>Example 2: Tiles missing on the wall next to the shower with exposed rusty metal protruding from<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the wall<br><br>Surveyor asked MD E (Maintenance Director) to observe what appears to be rusty metal protruding from the wall. MD E inspected the concern and stated it is rusty metal. MD E stated, he has not seen any order for this in the maintenance system. ANHA C (Assistance Nursing Home Administrator) stated this is the first time he is seeing this. MD E added, we need to repair the wall.<br><br>Example 3: Missing tiles on the shower floor<br><br>MD E (Maintenance Director) stated, these tiles need to be repaired.<br><br>Example 4: Dark substance along the inside right where the shower wall meets the floor. Tiles are broken and worn in this area as well.<br><br>MD E (Maintenance Director) stated, It needs to be cleaned.<br><br>Example 5: Vent above shower coated with dust; dust is visibly hanging off the vent<br><br>MD E (Maintenance Director) and ANHA (Assistant Nursing Home Administrator) stated, the vent is dirty and needs to be cleaned.<br><br>Example 6: Hairband in shower drain in the tub for one (1) week without being picked up. The shower is not being cleaned.<br><br>ANHA C (Assistant Nursing Home Administrator) stated, staff need to pick up items on the floor of the shower and it needs to be cleaned.<br><br>Of note, after Surveyors spoke with ANHA C (Assistant Nursing Home Administrator) and MD E (Maintenance Director) the shower room was closed for repairs.<br><br>Example 7<br><br>R67 admitted to the facility on [DATE] and has diagnoses that include conversion disorder with seizures or convulsions (a mental health condition where a person experiences physical symptoms that cannot be explained by a medical condition. These symptoms include seizures or convulsions) and generalized anxiety disorder.<br><br>On 9/30/25, at 3:00PM, Surveyor observed behind R67's bed above the headboard, approximately 30 inches above the floor, the wood chair rail was broken presenting a potential injury to the resident with splinters and sharp ends of wood exposed.<br><br>On 10/1/25, at 7:45AM, Surveyor interviewed MD E (maintenance director) and ANHA C (Assistant Nursing Home Administrator). Surveyor, MD E and ANHA C observed the broken chair rail in R67's room together. Surveyor asked if MD E and ANHA C were aware of the broken chair rail and ANHA C indicated he became aware of it on 9/25/25 when Life Safety brought it to his attention. Surveyor asked MD E and ANHA C if this could cause potential injury to R67 and ANHA C indicated yes. Surveyor expressed safety concerns to MD E and ANHA C and ANHA C agreed it was a safety concern and should not be left as showing. Surveyor asked if there was a work order or a plan to fix and ANHA C indicated the facility will pull the trim off, sand it down, and repaint it.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/1/25, at 11:01 AM, Surveyor interviewed R67. R67 indicated she had reported the broken chair rail weeks ago when she moved into that room. R67 expressed concern and indicated everything is always in a shamble here at the facility. R67 stated, My room just looks like it is shambles. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**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 48 residents (R42) reviewed for abuse. Facility did not report an abuse allegation involving R42 within the required two hours to the state agency (SA). Evidenced by:The facility policy entitled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 9/2022, states, in part: . Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation:Reporting Allegations to the Administrator and Authorities:1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:a. The state licensing/certification agency responsible for surveying/licensing the facility.3. Immediately is defined as:a. Within two hours of an allegation involving abuse or result in serious bodily injury. R42 was admitted to the facility on [DATE] and has diagnoses that include multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves that results in nerve damage that disrupts communication between the brain and the body.) and major depressive disorder. On 9/25/25, at 09:13 AM, Surveyor spoke with FM L (family member) who indicated it was a horrible weekend for R42. FM L indicated R42 reported to her cnas (certified nursing assistants) had come into R42's room Saturday 9/20/25 hot and ready to fight, saying horrible things to R42. FM L indicated the cnas were telling R42 that no one in the facility wants to work with her because she is so picky. The cnas were being nasty to R42 telling R42 they didn't have time to go back and forth between chairs with R42, so if R42 wanted in her recliner they would not come back and put her in her wheelchair to go to lunch because they don't have time. FM L indicated R42 had a bowel movement and the cnas did not clean R42 up in the front only the back side. FM L indicated she felt R42 was being emotionally abused, and FM L had reached out to [Name] from [Name of organization] to report abuse that Saturday morning (9/20/25) and DON B (Director of Nursing) and ANHA C (Assistant Nursing Home Administrator) were sent over to Ingleside. On 10/01/25, at 8:30 PM, Surveyor interviewed ANHA C who indicated that on Saturday 9/20/25 FM L contacted the head of the board of [Name of organization] and alleged abuse with R42, who passed it on to NHA A (Nursing Home Administrator). NHA A passed the information on to ANHA C. ANHA C indicated FM L did not indicate what specific type just a blanket abuse. ANHA C indicated he received the voicemail from NHA A at 11:13 AM on 9/20/25 and arrived at the facility 11:30-11:34AM and went straight to R42's room with a pen and paper. ANHA C indicated R42 made more of a conduct report regarding the cnas rather than abuse. Surveyor asked ANHA C what R42 reported and ANHA C indicated R42 stated the cnas were being rude and not welcoming. Surveyor asked how were the cnas being rude and not welcoming. ANHA C indicated she threw the trigger word out and stated she felt the cnas were being abusive. ANHA C indicated he started an investigation. Surveyor asked ANHA C if a report was filed with the state and ANHA C indicated no because he started investigating and found it unsubstantiated. Surveyor asked ANHA C if an allegation of abuse should be reported to the state. ANHA C<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated yes, and he is still learning. On 10/1/25, at 12:02PM, Surveyor interviewed NHA A. Surveyor asked NHA A what the facility policy says about reporting abuse; NHA A indicated an allegation of abuse needs to be reported within 2 hours to the state. CC D (corporate consultant) entered the office and indicated an allegation of abuse must be reported to the state within 2 hours. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff did not provide care and treatment in accordance with professional standards of practice for 3 of 4 sampled residents (R51, R6 & R23) and 1 of 1 Supplemental Residents (R69).<br><br>R51 was admitted to the facility with a surgical wound. R51's wound treatments were not completed as ordered by the physician.<br><br>R6 had a change of condition and did not have documented assessments through the course of antibiotic treatment.<br><br>R23 had a change of condition and did not have documented assessments through the course of antibiotic treatment.<br><br>R69 admitted to the facility on antibiotic for infection and did not have documented assessments through the course of antibiotic treatment.<br><br>This is evidenced by:<br><br>The facility policy titled, Wound Care, dated 10/2010, states, in part: . Documentation The following information should be recorded in the resident's medical record:. 2. The date and time the wound care was given. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size drainage, etc.) obtained when inspecting the wound. 9. If the resident refused the treatment and the reason(s) why. Reporting 1. Notify the supervisor if the resident refuses wound care. 2. Report other information in accordance with facility policy and professional standards of practice.<br><br>Example 1<br><br>R51 was admitted to the facility on [DATE], with diagnoses including [NAME] cell carcinoma (Aggressive skin cancer), aftercare following surgery for neoplasm (abnormal tissue growth), neoplasm related pain (acute) (chronic), unspecified severe protein-calorie malnutrition, adult failure to thrive, cognitive communication deficit, and unspecified open wound of left buttock.<br><br>R51's Minimum Data Set with Assessment Reference Date 9/25/25 indicates R51 has a Brief Interview for Mental Status score of 15 out of 15, indicating R51 is cognitively intact.<br><br>R51's Physician Orders indicate, in part:<br><br>WOUND CARE: L. (Left) Thigh – Cleanse with soap and water; pat dry; apply Vaseline Gauze; Cover with ABD; Wrap with ACE bandage. Once A Day. Start Date: 8/15/25. End Date: 8/29/25. Discontinued Order.<br><br>WOUND CARE: Left Hip/Buttock – Cleanse with soap and water; pat dry; apply Silvadene (or generic equivalent); Pack wound with kerlix; cover with ABD; Secure with Tape. Twice A Day. Start Date: 8/15/25. End Date: 8/19/25. Discontinued Order.<br><br>WOUND CARE: Left Hip/Buttock – Cleanse with soap and water; pat dry; apply Silvadene (or generic equivalent); Pack wound with kerlix; cover with ABD; Secure with Tape. Twice A Day.<br><br>(continued on next page) |

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| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R51's Medication Administration Record (MAR) indicates, in part:<br><br>On 8/15/25, R51 did not receive her wound care according to provider orders for her left hip/buttock wound. The MAR contains the comment: Drug/Item Unavailable.<br><br>On 8/16/25, R51 did not receive her wound care according to provider orders for her left thigh and left hip/buttock wounds. The MAR contains the comment: pt (patient) load/staffing for her left hip/buttock wound.<br><br>On 8/24/25, R51 did not receive her wound care according to provider orders for her left thigh and left hip/buttock wound. The MAR contains the comment: not enough time in shift for amount of work to be done for one nurse for the left thigh wound and left hip/buttock wound.<br><br>On 8/27/25, R51 did not receive her wound care according to provider order for her left thigh and left hip/buttock wounds.<br><br>R51's Progress Notes indicate, in part:On 8/25/25 at 12:46 PM, a Progress Note is written that states, in part: Writer arrived to start shift to find agency RN 'overwhelmed' stating she wasn't able to get to (R51's Room Number) wound d/t (due to) being short staffed and too many patients. Writer immediately went to change wound and found it w (with) moderate purulent drainage and some bloody discharge. Also observe surgical incisions being wider and wetter than when she first got here.<br><br>On 10/1/25 at 2:00 PM, Surveyor interviewed DON B (Director of Nursing) and IP G (Infection preventionist). Surveyor asked DON B and IP G if they expect wound care treatments to be completed according to provider orders. DON B indicated, yes, unless the resident refuses, then the refusal should be documented.<br><br>R51's surgical wound treatments were not completed as ordered by the physician.<br><br>Example 2<br><br>R6 admitted to the facility on [DATE] and has diagnoses that include: acute pyelonephritis-Right sided (an infection of the kidneys); personal history of urinary infections; retention of urine (the inability to completely empty the bladder which can lead to infection)<br><br>R6's Physician Orders include Sulfamethoxazole-trimethoprim (an antibiotic) 800-160 mg (milligrams) Take 2 tablets by mouth BID (twice a day) for 7 days d/t (due to) MDRO (multi-drug resistant organism) proteus (a bacterium which causes infection) on culture. Start date 7/28/25.<br><br>During record review Surveyor was unable to locate any assessments or continued monitoring for R6 after having a change in condition with a UTI (urinary tract infection).<br><br>Surveyor requested documentation related to assessment of symptoms of urinary tract infection through completion of antibiotic treatment.<br><br>No documentation was provided by the facility. Example 3<br><br>R23 admitted to the facility on [DATE] and has diagnoses that include: urinary tract infection; hydronephrosis with renal and ureteral calculous obstruction (a condition where the kidney becomes<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | swollen due to a blockage caused by kidney stones)<br><br>R23's Physician Orders include Sulfamethoxazole-trimethoprim 800-160 mg Take 1 tablet by mouth 2 times daily at mealtime for 3 days for infection. Start date 6/18/25.<br><br>During record review Surveyor was unable to locate any assessments or continued monitoring for R23 after having a change in condition with a UTI.<br><br>Surveyor requested documentation related to assessment of symptoms of urinary tract infection through the completion of antibiotic treatment.<br><br>No documentation was provided by the facility. Example 4<br><br>R69 admitted to the facility on [DATE] and has diagnoses that include: cystitis; chronic kidney disease (a condition in which the kidneys lose their ability to filter waste products)<br><br>R69's Physician Orders include Cefdinir (antibiotic) 300 mg Take 1 capsule by mouth once daily. Start date 7/18/25.<br><br>R69's Progress notes include 7/18/25 at 2:36 PM Resident admitted to facility today.foley present and draining clear yellow urine.<br><br>During record review Surveyor was unable to locate continued assessments or monitoring for a UTI.<br><br>Surveyor requested documentation related to assessment of symptoms of urinary tract infection through the completion of antibiotic treatment.<br><br>No documentation was provided by the facility.<br><br>On 9/30/25 at 3:21 PM, Surveyor interviewed IP G (Infection Preventionist) and asked about monitoring of residents on antibiotics. IP G stated that through the course of the antibiotic the resident should have an assessment of vital signs and the body system involved, along with any signs and symptoms of adverse reaction to the antibiotic. IP G stated that symptom surveillance had been a noted issue. Surveyor asked if R6, R23 and R69 were assessed through the course of their antibiotic treatment. IP G stated no, R6 and R23 needed to have urinary assessments through the course of their antibiotics and that while R69 had an assessment on 7/18/25, assessment would be expected through 7/22/25.<br><br>On 10/1/25 at 9:50 AM, Surveyor interviewed DON B (Director of Nursing) Surveyor asked about residents on antibiotics. DON B stated that assessments should be done and documented through the course of the antibiotic. DON B stated it is the facility's plan to educate staff and make sure that this is occurring.<br><br>R6, R23 and R69 did not have documented assessments through the course of their antibiotic treatment. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not implement professional standards of practice to prevent pressure injuries (PIs) from developing and/or worsening or to promote healing of PIs for 2 of 6 residents (R28 and R4) reviewed for PIs out of a sample of 19 residents.<br><br>R28 was admitted to the facility with four (4) Stage 1 PIs. R28 was at risk for further PI development and had significant comorbidities. The facility failed to complete a readmission skin assessment, accurately complete all wound assessments and measurements, notify the provider of changes to the PI, offload pressure, and follow standards of practice during wound care. R28 developed an Unstageable PI which deteriorated to a Stage IV (4) PI with osteomyelitis.<br><br>R4 was admitted [DATE] without any pre-existing pressure injuries. R4 has developed 4 unstageable pressure injuries and was diagnosed with cellulitis that required IV antibiotics to treat. R4's initial pressure injury care plan was not put in place until 4/2025 and contained few interventions for pressure off-loading. R4 had only two Braden Scales for Pressure Injury Risk conducted since admission, which should have been completed upon readmission from the hospital and at least quarterly. R4 did not receive several wound treatments and missed several weekly wound assessments.<br><br>The failures to complete readmission skin assessments, notify a provider of PI changes, offload pressure, complete wound treatments as ordered, and follow wound care standards of practice created a finding of immediate jeopardy that began on 5/2/25. NHA A (Nursing Home Administrator) was informed of the immediate jeopardy on 10/1/25 at 5:09 PM. The immediate jeopardy was removed on 10/4/25, however, the deficient practice continues at a scope/severity of D (potential for harm/isolated) as the facility continues to implement its action plan.<br><br>Findings include:<br><br>The NPIAP (National Pressure Injury Advisory Panel) classifies a PI as follows:<br><br>Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts may be associated with Stage 4 pressure ulcers.<br><br>Unstageable: Obscured full-thickness skin and tissue loss full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.<br><br>Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the extent of tissue injury, or many resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury. (Unstageable, Stage 3 or Stage 4).<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The facility's Pressure Injury Prevention Guidelines, undated, indicate in part, as follows: Preventative Skin Care: 1. Inspect skin while providing care, paying close attention to bony prominences; 2. Inspect skin underneath medical devices at least twice daily. Keep skin clean and dry underneath. Adjust devices as needed for proper fit.<br><br>The facility policy, Pressure Injury Risk Assessment, revised March 2020, documents, in part, as follows: The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs). General Guidelines: Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. The interventions must be based on current, recognized standards of care. The effects of the interventions must be evaluated. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate.<br><br>The facility policy, Prevention of Pressure Injuries, revised April 2020, documents, in part, as follows: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Skin Assessment: Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. Reposition resident as indicated on the care plan. Weekly RN (Registered Nurse) assessment and documentation completed. Wound rounds must be completed at a minimum of at least once every 7 days. Measurements and documentation to support treatment, interventions, type of wound must be part of the weekly documentation. MD (Medical Doctor) must be notified of any changes in wound. Mobility/Repositioning: Reposition all resident with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary team. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines.<br><br>The facility policy, Cleaning and Disinfection of Resident-Care Items and Equipment, revised October 2018, documents, in part, as follows: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection.Reusable items are cleaned and disinfected or sterilized between residents.<br><br>The facility's policy, Handwashing/Hand Hygiene, revised August 2019, states in part: This facility considers hand hygiene the primary means to prevent the spread of infections. Wash hands with soap and water for the following situations: When hands are visibly soiled.Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: .Before and after direct contact with residents; Before handling clean or soiled dressings, gauze pads, etc.; After contact with blood or bodily fluids; After handling used dressings.; After contact with objects in the immediate vicinity of the resident; After removing gloves; Before and after entering isolation precaution settings.<br><br>The facility policy titled, Purpose and Instructions for the Braden Scale for Pressure Sore Risk, undated, states, in part: Pressure sore risk screening tools assist in wound prevention as they identify those persons who are at risk for pressure ulcer development, from those who are not. The purpose of identifying those at risk is to allow for appropriate use of resources for prevention. Risk<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Level Risk Score -At Risk 15-18. Suggested interventions have been developed based on risk scores. Interventions should be individualized and include review of the following; -Support surfaces for wheelchair/chair and or bed -Frequent position changes, mobilize and or move your resident -Nutritional interventions -Appropriate skin care routine -Routine skin inspection. Frequency of pressure ulcer assessments [sic] depends on your health care setting: Long-Term Care: -On admission and then weekly for four weeks, and then quarterly -Upon readmission from hospital -With any significant change in health status.<br><br>The facility policy titled, Wound Care, dated 10/2010, states in part: .Documentation The following information should be recorded in the resident's medical record: 2. The date and time the wound care was given. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size drainage, etc.) obtained when inspecting the wound. 9. If the resident refused the treatment and the reason(s) why. Reporting 1. Notify the supervisor if the resident refuses wound care. 2. Report other information in accordance with facility policy and professional standards of practice.<br><br>R28 admitted to the facility on [DATE] with diagnoses including but not limited to idiopathic peripheral neuropathy (a type of nerve damage where the underlying cause is unknown), gait instability (unsteady pattern of walking that increases the risks of falls,) and generalized weakness. She is wheelchair bound at baseline but usually does her own transfers and is now unable.<br><br>On 12/17/24, R28's hospital report documents as follows: Fractured styloid process right radius (fractured thumb) . R28 has had worsening generalized weakness since 11/27/24, she states that her arms and legs feel weak. She normally uses a walker, recently she has been using a wheelchair due to increased weakness. She is wheelchair bound at baseline but usually does her own transfers and is now unable.<br><br>R28's admission Minimum Data Set (MDS) dated [DATE] indicates R28 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. R28's MDS indicates she is at risk for PI development and was admitted with four (4) Stage 1 PIs.<br><br>On 12/17/24, a Registered Nurse (RN) completed R28's Weekly Skin Check.<br><br>Any reddened areas that do not resolve after pressure is reduced: Yes, buttock, back, and bilateral heels<br><br>Any open ulcers: No<br><br>On 12/24/25 at 9:59 AM, an RN (Registered Nurse) completed R28's Weekly Skin Check.<br><br>Any reddened areas that do not resolve after pressure is reduced: No<br><br>R28's CNA (Certified Nursing Assistant) Kardex, documents the following:<br><br>Transfers: Hoyer lift (Start Date: 12/20/24)<br><br>Ambulation: Therapy only (Start Date: 12/18/24)<br><br>Mobility Devices: Uses wheelchair (Start Date: 12/18/24).<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Pressure Ulcer/Injury: Start Date: 12/26/24 Avoid shearing resident's skin during positioning, transferring, and turning.<br><br>Pressure Ulcer/Injury: Start Date: 12/26/24 Conduct a systematic skin inspection with daily cares and bathing activities. *Reposition/offload at least every 2-3 hours and PRN (as needed) for skin protection and comfort.<br><br>Pressure Ulcer/injury: Start Date: 12/26/25 Keep clean and dry as possible. Minimize skin exposure to moisture.<br><br>Pressure Ulcer/Injury: Start Date: 7/28/25 EBP (Enhanced Barrier Precautions) due to wound and foley. DON gown and gloves when providing care.<br><br>R28's comprehensive care plan indicates the following:<br><br>Problem Start Date: 12/26/24 Pressure ulcer/Injury R28 is at risk for skin breakdown r/t (related to) limited mobility, occasional incontinent of B&B (bowel and bladder), potential for falls. Long Term Target Date 10/18/25: R28's wound will not have s/s (signs/symptoms) of infection.<br><br>Approach start date: 7/28/25 EBP (Enhanced Barrier Precautions) due to wound and foley. DON (put on) gown and gloves when providing care.<br><br>Approach Start Date: 12/26/24 Avoid shearing resident's skin during positioning, transferring, and turning.<br><br>Approach Start Date: 12/26/24 Conduct a systemic skin inspection with daily cares and bathing activities. Reposition/offload at least every 2-3 hours and PRN (as needed) for skin protection and comfort.<br><br>Approach Start Date: 12/26/24 Keep clean and dry as possible. Minimize skin exposure to moisture.<br><br>Approach Start Date: 12/26/24 Keep skin lubricated.<br><br>It is important to note, the care plan documents Reposition/offload at least every 2-3 hours.<br><br>On 12/30/24, R28 was admitted to the hospital under observation. R28 returned to the facility on [DATE] with diagnoses including, but not limited to, chronic heart failure (heart is not functioning properly) and failure to thrive (a decline resulting in weight loss and weakness).<br><br>It is important to note the facility did not complete a readmission skin assessment on 1/7/25.<br><br>Of note, there is no documentation in the hospital that R28 has a PI.<br><br>On 1/7/25, R28 enrolled in hospice services.<br><br>Initially, hospice was measuring and assessing R28's PI. It is important to note, the facility had no documentation of R28's weekly PI measurements and assessments for approximately 3 months until requested by Surveyor. The facility obtained requested documentation from hospice after Surveyor requested the PI assessments.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 1/8/25 at 1:00 PM, hospice completed the following Initial PI assessment:<br><br>Wound Assessment: Boggy, Intact, Purple<br><br>Location: Heel Deep Tissue Injury<br><br>Peri-wound: Dry, Intact<br><br>Drainage: None<br><br>Measurements: 3.0 x 3.0 cm (centimeters)<br><br>Margins: Well-defined edges<br><br>Pressure Injury: Deep Tissue<br><br>Wound Cleansing: Soap and water<br><br>Interventions: Air Dry<br><br>Dressing Status: None<br><br>On 1/13/25, R28's Braden Assessment (a measure of pressure injury risk) indicates R28 is at risk for PI development.<br><br>1/16/25 (Hospice)<br><br>Wound Assessment: Boggy, Fragile/Friable, Moist, Purple<br><br>Peri-wound: Dry, Intact<br><br>Drainage: Small Serosanguineous<br><br>Measurements: 4.0 x 4.0 cm<br><br>Margins: Well-defined edges<br><br>Pressure Injury: Deep Tissue<br><br>Wound Cleansing: Wound cleanser Foam border (Allevyn/Aquacel/Mepilex/Optifoam)<br><br>Dressing Status: Clean, dry, intact<br><br>Dressing change: Done<br><br>(Note: PI increased in size and now has drainage.)<br><br>No significant changes in the wound are documented by hospice in weekly assessments from 1/23/25 through 3/5/25.<br><br>(continued on next page) |

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|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/4/25, R28's Bath Sheet documents No open areas. Note, this is inaccurate.<br><br>On 3/11/25, R28's Bath Sheet documents No open areas. Note, this is inaccurate.<br><br>3/12/25 (Hospice)<br><br>*Wound Assessment: Black, Dry, Fragile/Friable, Moist, Pink<br><br>Peri-wound: Boggy, Dry, Intact<br><br>Drainage: Serosanguinous<br><br>Measurements: 4.0 x 4.0 cm (centimeters)<br><br>Topical Wound Treatment: Betadine<br><br>Dressing: Foam border (Allevyn/Aquacel/Mepilex/Optifoam)<br><br>Dressing Status: Clean, dry, intact<br><br>On 3/13/25, R28's Provider visit indicates Reason: Weekly Visit, hospice SKIN-no masses, no rashes, no lesion on exposed skin.<br><br>On 3/14/25, NP M (Nurse Practitioner) conducted an initial evaluation of R28's PI.<br><br>Diagnosis that could affect wound healing: Heart failure, generalized weakness, obesity, lower extremity edema, hyperlipidemia, hypertension<br><br>Physical Examination: Left heel unstageable pressure ulcer measuring 3.0 cm x 5.0 cm with 10% slough and 90% eschar. Small serous drainage. Wound examined, noted to have foul odor and some maceration to periwound. Tx (treatment) plan discussed with hospice.<br><br>Status: Initial evaluation<br><br>Plan: Cleanse wound paint with Betadine cover with ABD (dressing) and Kerlix daily<br><br>Assessment<br><br>Pressure ulcer of left heel, unstageable: Unstageable pressure ulcer to left heel with primarily eschar and some slough to perimeter of wound. There is a foul odor noted. Treatment plan adjusted for moisture control. Plan of care discussed with hospice nursing and facility nurse as well as patient<br><br>Adult failure to thrive: Adult failure to thrive-now on hospice care.<br><br>Unspecified diastolic (congestive) heart failure: No medical management. Hospice following. 2–3+ pitting pedal edema bilaterally. Elevate lower extremities as tolerated throughout the day.<br><br>On 3/18/25 at 8:05 PM, R28's Progress Notes include the following: Resident seen for initial evaluation in weekly wound rounds with wound NP, NP M, and wound RN per request from hospice RN. (It is<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | important to note, the wound RN is not wound care certified.) 0/10 pain reported. Wound assessment: Unstageable pressure ulcer to left heel with wound bed eschar and some slough to perimeter of wound. Foul odor present. See wound management documentation. Treatment plan adjusted for moisture control. Plan of care discussed with hospice nurse. New wound care orders placed per hospice MD (Medical Doctor).<br><br>On 3/18/25, R28's Wound Management Detail Report documents as follows: 3.0 x 5.0 cm Stage: Unstageable-Slough and/or Eschar Exudate: Moderate serous Wound odor present: Yes Describe: Foul. Undermining: No Tunneling: *Note, there is no description of the PI wound bed or peri-wound.<br><br>On 3/21/25 at 11:39 PM, R28's Progress Note documents the following: LVM (left voice mail) for hospice RN requesting PRN (as needed) MS04 (Morphine sulfate) medication) 7.5mg (milligrams) be scheduled nightly; (R28's name) does not complain; but when asked if she has pain, she always says yes. When offered her low-dose narcotic at HS (bedtime) she always accepts. As well her heel could use some help; requested treatment change to include Santyl or SSD (silver sulfadiazine – an antibiotic cream used to prevent and treat infections.) Will call back 3/22. Just found fax from earlier with updated orders for heel incl (including) Silvadene; Matrix updated.<br><br>On 3/22/25 at 2:10 PM, Just received fax to update MS (Morphine Sulfate) order to schedule daily at bedtime; matrix updated.<br><br>On 3/26/25 Hospice Notes document in part as follows: Wound Assessment: Brown, Boggy, Eschar, Fragile/Friable, Moist, Painful, Slough (Percentages not indicated)<br><br>Periwound: Fragile, Moist, Painful, Pink<br><br>Drainage: Moderate<br><br>Drainage Description: Brown, Malodorous, Serosanguineous, Yellow<br><br>Measurements: 5.0 x 3.0<br><br>Margins: Well-defined edges<br><br>Pressure Injury Stage: U (Unstageable)<br><br>Wound cleansing: Soap and water<br><br>Topical wound: Betadine, Silvadene<br><br>Dressing: ABD, Gauze fluff roll (Kerlix)<br><br>Dressing status: Clean, dry and intact<br><br>Dressing changed: Done<br><br>On 4/2/25, R28's Wound Management Detail Report documents as follows: 3.0 x 5.0 Can depth be measured: No - Unstageable - Slough and/or eschar Tissue Type: NECROTIC.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 4/9/25, Hospice notes document as follows:<br><br>Measurement: 5.0 x 2.0. Unable to determine depth d/t (due to) eschar/necrotic tissue present.<br><br>Wound Assessment: Brown, Boggy, Eschar, Fragile/Friable, Granulation tissue, Moist Necrotic, Painful 80%eschar 20% yellow slough<br><br>Periwound: Fragile, Moist<br><br>Drainage: Moderate<br><br>Drainage Description: Brown, Malodorous, Tan, Yellow<br><br>On 4/11/25, NP M completed R28's Wound Care Assessment.<br><br>Chief Complaint: Evaluation of unstageable pressure ulcer<br><br>Subjective: Patient seen today for follow-up regarding unstageable pressure ulcer left heel. She was not seen last week due to facility reporting they would be managing her wound however now being requested to follow by hospice. Wound examined today with large eschar demarcating and underlying slough present. There is foul odor. Patient reports moderate amount of pain constantly to that heel. She denies any fevers or chills. Verbal consent obtained today to debride eschar. Area debrided with patient tolerating well. Post debridement with 100% slough to wound bed and significant undermining as noted below. Plan of care adjusted and discussed with patient, nursing, as well as hospice today.<br><br>Interventions in place: Offloading measures per facility protocol, nutritional support, comfort measures with hospice services in place, weekly wound assessment with treatment plan as directed.<br><br>Physical Examination: Left heel, unstageable PI measuring 2.5 cm x 4.5 cm with 100% demarcated eschar and moderate serous drainage with foul odor. Eschar removed with surgical debridement performed after verbal consent obtained from patient. There is 100% slough beneath eschar (dead, necrotic tissue). Wound measuring 2.5 cm x 4.5 cm with undermining circumferentially with deepest aspect at 6:00 measuring 3.6 cm. Unable to fully visualize extent of wound bed given depth of undermining. *Status: Declined<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakin's dampened gauze followed by ABD and Kerlix to be changed daily and as needed. Continue offloading measures.<br><br>On 4/18/25, NP M completed R28's Wound Care Assessment.<br><br>Physical Examination: Left heel unstageable pressure ulcer measuring 2.4 cm x 3.3 cm x UTD (undetermined) with 100% slough, with undermining circumferentially with deepest aspect at 6:00 measuring 3.4 cm. Unable to fully visualize extent of wound bed given depth of undermining. Moderate serous drainage.<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakins dampened gauze followed by ABD and Kerlix to be changed daily and as needed. Continue offloading measures.<br><br>On 4/25/25, NP M completed R28's Wound Care Assessment.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Wound Care Assessment: Left heel unstageable pressure ulcer measuring 2.2 cm x 3.5 cm x 1.0 cm with undermining from 5:00 to 7:00 with deepest aspect measuring 3.5 cm at 6:00. Wound appears to be 20% slough and 80% granulation however unable to fully visualize extent of wound bed given depth of undermining. Moderate serosanguineous drainage.<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakin's dampened gauze followed by ABD and Kerlix to be changed daily and as needed. Continue offloading measures.<br><br>On 5/1/25, R28's orders contain the following: Juven with collagen added to orders twice daily.<br><br>On 5/2/25, NP M completed R28's Wound Care Assessment.<br><br>Physical Examination: *Left heel Stage 4 pressure ulcer measuring 1.8 cm x 3.2 cm x 0.8 cm with undermining from 5:00 to 7:00 with deepest aspect measuring 3.7 cm at 6:00. Unable to fully visualize wound bed due to depth however visible area of wound bed is 100% granulation and there is moderate amount of serosanguineous drainage. There does appear to be bone probable to undermining area. Moderate serosanguineous drainage. Status: Improved<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakin's dampened gauze followed by ABD and Kerlix to be changed daily and as needed. Recommending Dakin's be changed to Vashe given granulation tissue present and facility will potentially provide, discussed with ADON (Assistant Director of Nursing). Continue offloading measures.<br><br>On 5/9/25, RN N documented the following PI assessment for R28: Stage 4 measuring 2.3 x 3.5 x 1.4 undermining circumferentially with deepest aspect at 6 measuring 3.3 cm and 100% granulation with wound bed not well visualized. Moderate serosanguinous drainage noted.<br><br>On 5/16/25, NP M completed R28's Wound Care Assessment.<br><br>Physical Examination: Left heel stage 4 pressure ulcer measuring 1.9 cm x 3.0 cm x 1.1 cm with undermining from 4:00 to 7:00 with deepest aspect measuring 3.0 cm at 6:00. Unable to fully visualize wound bed due to depth however visible area of wound bed is 100% granulation and there is moderate amount of serosanguinous drainage. Bone probable to undermining area. Moderate serosanguineous drainage. Status: Stable<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakin's dampened gauze followed by ABD and Kerlix to be changed daily and as needed. Recommending Dakin's be changed to Vashe given granulation tissue present and facility will potentially provide.<br><br>On 5/23/25, NP M completed R28's Wound Care Assessment.<br><br>Wound Care Assessment: Left heel Stage 4 pressure ulcer measuring 2.3 cm x 3.0 cm x 0.5 cm with undermining from 4:00 to 7:00 with deepest aspect measuring 3.4 cm at 6:00. Unable to fully visualize wound bed due to depth however visible area of wound bed is 100% granulation and there is moderate amount of serosanguinous drainage. Bone probable to undermining area. Status: stable<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakin's dampened gauze followed by ABD and Kerlix to be changed daily and as needed.<br><br>(continued on next page) |

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|---|---|---|---|
| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 5/30/25, NP M completed R28's Wound Care Assessment.<br><br>Wound Care Assessment: Left heel Stage 4 pressure ulcer measuring 1.7 cm x 3.0 cm x 1.3 cm with undermining from 4:00 to 7:00 with deepest aspect measuring 3.0 cm at 6:00. Unable to fully visualize wound bed due to depth however visible area of wound bed is 100% granulation and there is moderate amount of serosanguinous drainage. Bone probable to undermining area. Foul odor.<br><br>Plan: Cleanse wound gently/loosely packed with quarter strength Dakins dampened gauze followed by ABD and kerlix to be changed daily and as needed. Add powdered Flagyl (an antibiotic) to be sprinkled over gauze just packed loosely into the wound for odor control.<br><br>On 9/26/25, R2's Stage 4 PI to her left heel has not healed. The Wound Management Detail Report documents as follows: 1.9 x 2.4 Irregular wound edges. Surrounding skin: Dark purple or rusty discoloration; Edema; [NAME] or grey pallor<br><br>It is important to note, on 9/26/25 the facility discovered a new PI to R28's left heel superior (above) the existing Stage 4 PI. The Wound Management Detail Report documents the following: 1.9 x 2.4 Can depth be measured: No Exudate: None Wound odor: None Stage: Unstageable – Deep Tissue Injury Undermining Present: No Sinus tract/tunneling: No Tissue Type: Closed/Resurfaced Wound Edges: Irregular wound edges Skin Surrounding Wound: Dark purple or rusty discoloration; Edema; [NAME] or grey pallor<br><br>On 9/29/25 at 10:50 AM, Surveyor observed RN N complete R28's dressing changes. RN N stated she has worked as the wound care nurse at the facility since April 2025. Surveyor observed RN N put on a gown and then use hand sanitizer. While standing at the cart, RN N put on a pair of dirty gloves from the keyboard, picked up gauze, sprayed it with Integrity Wound Cleanser and carried this along with other supplies into R28's room. While holding onto the supplies, RN N set a drape on the bed. Surveyor observed R28's heels directly on a pillow and not floated (not wearing boots). Surveyor asked RN N, should R28's heels be floated. RN N stated, R28 usually has the foam boots on while in bed however, she asked CNAs (Certified Nursing Assistants) to leave them off. Surveyor asked RN N, how long have R28's boots been off. RN N stated about 15 minutes. Surveyor asked RN N, should R28's heels be floated. RN N stated, yes. Surveyor observed RN N ask R28 if she is having any pain. R28 stated her pain is at a 5 or 6 and she got pain medication already. Surveyor observed RN N cut the kerlix wrap from R28's ankle to her foot with a scissors she pulled from her pocket. Surveyor observed a new PI actively bleeding above R28's existing Stage 4 PI to her left heel. Surveyor asked RN N about this new PI. RN N stated this new area was discovered on 9/26/25 and it is located above R28's Stage 4 PI. RN N stated, this is a new DTI (Deep Tissue Injury). Surveyor asked RN N, how would you describe the new DTI. RN N stated, depth unable to determine, periwound red, purple, and boggy. RN N stated, R28 has had a longstanding Stage 4 to her left heel as there is bone probable. RN N added, R28 has a history of undermining to the left heel wound with current undermining present from 12:00-2:00. The wound bed is 100% granulation with moderate serosanguinous drainage, and a callous to the periwound. RN N stated, the new DTI will remain Unstageable until it opens. Note, Surveyor observed the new DTI to be actively bleeding during the treatment. At this point during the dressing change, RN N has removed a soiled dressing without removing her gloves, sanitizing her hands and donning new gloves. Surveyor observed RN N apply skin prep around the Stage 4 PI. Surveyor observed RN N use dirty scissors that were in her pocket and used to cut off the old dressing to also cut Medline Calcium Alginate to pack the Stage 4 PI. It is important to note, this is cross contamination; in addition, R28 likely has osteomyelitis per interview with NP M (below). Surveyor observed RN N remove her gloves and don new gloves. Of note, RN N did not sanitize her hands in between glove changes. RN N stated she told<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | staff to wrap the kerlix above and below the resident's ankle, so the dressing does not migrate. Surveyor asked RN N, what is the cause of R28's new PI. RN N stated, she thinks the dressing migrated and moved on that area causing pressure. Surveyor observed RN N apply an ABD and kerlix to R28's foot and ankle, remove her gloves and wash her hands in the bathroom sink, apply tubigrips to R28's bilateral feet, set dirty scissors on a single layer of gauze, take a second piece of gauze, apply hand sanitizer, wipe scissors, and set it on dirty single layer of gauze (permeable and not using a barrier) underneath it.<br><br>On 9/29/25 at 11:13 AM, Surveyor spoke with RN N. Surveyor asked RN N, where did you have your scissors. RN N stated, I should have had them out of my pocket, obviously they're cleansed from the other patient. Surveyor asked RN N, do you normally use hand sanitizer to disinfect scissors. RN N stated here she does as she does not have Sani Wipes. RN N stated usually she uses the purple Sani Wipes with 2-minute contact time. Surveyor asked RN N, should you have the scissors on a clean solid barrier. RN N stated, Yes, I should have used a drape. Surveyor asked RN N, should you disinfect scissors in between dirty and clean. RN N stated, Yes. Surveyor asked RN N, after you cut the existing kerlix off should you have disinfected the scissors before cutting the Calcium Alginate. RN N stated, Yes. Surveyor asked RN N, when should you change gloves. RN N stated, When going from dirty to clean. Surveyor stated, after removing the existing dressing and before packing the PI should you have removed your gloves, sanitized your hands, and donned new gloves. RN N stated, Yes.<br><br>On 9/29/25 at 4:12 PM, Surveyor spoke with DON B (Director of Nursing who has been in her role since 9/18/25. Surveyor asked DON B, how often are PIs to be measured and assessed. DON B stated every 7 days. Surveyor asked DON B, on 1/7/25 when R28 readmitted to the facility should staff have completed a readmission skin assessment. DON B stated, yes. Surveyor asked DON B, on 2/27/25 during R28's weekly PI assessment and measurement, should staff have measured R28's PI. DON B stated, yes. Surveyor asked DON B, do you expect staff to float residents' heels. DON B stated, yes. Surveyor asked DON B, do you expect staff to turn and reposition residents that require assistance with turning and repositioning. DON B stated, yes. Surveyor asked DON B, how often do you expect staff to turn and reposition residents. DON B stated every 2 hours. Surveyor asked DON B, where is turning and repositioning documented. DON B stated, turning and repositioning is care planned. DON B added, if a physician wants this ordered, we'll get an order. Surveyor asked DON B, is turning and repositioning documented. DON B stated, if they have an order for it, yes. Surveyor asked DON B, does R28 have an order for turning and repositioning. DON B stated, no, she does not see one. Surveyor asked DON B who discovered R28's PI to her left heel. DON B stated, It looks like on 3/14/25 the NP documented it. Surveyor asked DON B, how often should staff be checking R28's heels. DON B stated, staff should be checking R28's heels during a weekly skin assessment. Surveyor asked DON B, on 4/2/25 when R28's PI is documented as necrotic was a provider notified. DON B stated, no, but they should have been. Surve |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident with a catheter receives appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (R42) reviewed for catheter care. Staff attached a dirty leg bag with urine in the bag and the tube after removing R42's catheter bed bag.Evidenced by:The facility policy entitled, Urinary Leg Drainage Bags, dated October 2010, states, in part: . Purpose: The purpose of this procedure is to provide guidelines to decrease the likelihood of nosocomial urinary tract infections associated with the intermittent use of leg drainage bags with foley catheters.General Guidelines: .3. A new sterile drainage bag should be used every time the regular straight drainage tubing is disconnected, and the leg bag is used.6. Do not wash or disinfect leg bags in an attempt to reuse them. R42 admitted to the facility on [DATE] and has diagnoses that include neuromuscular dysfunction of bladder (occurs when there is damage or dysfunction in the nerves or muscles that control bladder function) and urinary incontinence (loss of bladder control).R42's Care Plan, dated 8/07/25, states, in part: . Problem: Category: Indwelling Catheter. Resident requires a suprapubic catheter.Goal: Long Term Goal Target Date: 11/06/25. Resident will have suprapubic catheter care managed appropriately as evidenced by not exhibiting obstruction, signs of infection, dislodgement of catheter, bowel perforation, or trauma.Approach: .Approach Start Date: 8/07/2025. Keep catheter system a closed system as much as possible.Approach Start Date: 8/07/2025. Manipulate tubing as little as possible during care.On 9/24/25, at 1:57PM, Surveyor interviewed R42. R42 expressed concern with catheter care she receives. R42 indicated she has had several urinary tract infections since being at the facility. R42 indicated the facility reuses the catheter bags, and they do not always cleanse them. R42 indicated when the staff reconnect the ends of the catheter tubing they don't always wash the ends. R42 expresses concern that she is afraid she is going to get a urinary tract infection. On 9/29/25, at 8:39AM, Surveyor observed CNA R (certified nursing assistant), and AN Q (Admissions nurse) perform catheter care. AN Q grabbed the old leg bag out of R42's bathroom that had a small amount of urine in the bag and tube. AN Q cleansed the end of leg bag tubing with alcohol wipes. The bed bag was removed from R42, and the leg bag was attached. The bed bag was taken into R42's bathroom and hung-over towel rack with urine noted in the tubing. On 9/29/25, at 9:03AM, Surveyor interviewed AN Q and CNA R and asked how long the bed bags and leg bags are used for before they are replaced with new ones. Both AN Q and CNA R indicated not knowing. Surveyor asked how long has R42's bags been in use, and AN Q and CNA R indicated not knowing. Surveyor asked if the catheter bags should be dated if being reused and AN Q and CNA R indicated not knowing. Surveyor asked what the process is for cleansing the bags before reusing. AN Q indicated they should have water run through them and vinegar if the facility has it. Surveyor asked when you would expect the bags to be cleansed, and AN Q indicated once a day by the night shift. Surveyor repeated to AN Q and asked, the process is the bag gets removed from R42's catheter and hung in the bathroom for the night shift to wash out; the leg bag hanging in the bathroom then gets applied to R42's catheter? AN Q indicated yes. Surveyor asked if the leg bag had been cleansed when it was just applied to R42, and AN Q indicated I don't recall I was alcoholing the end of the leg bag's tubing. Surveyor informed AN Q there was urine still in leg bag and the bottom tube of the leg bag. AN Q indicated it should have been cleansed out and was not. It should not have been applied without being cleansed out.On 9/29/25, at 9:20AM, AN Q returned to Surveyor and indicated he has information on questions that were asked. AN Q indicated if a resident has high sedimentation rates in their urine their catheter bags gets changed out<br><br>(continued on next page) |

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|---|---|---|---|
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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | weekly, and if a resident has normal output the catheter bags gets changed monthly. Surveyor asked AN Q how would the cnas know when to change the bags if they are not dated, and AN Q indicated the nurses keep track and hand the new bags out when it is due to be changed. On 9/30/25, at 10:47AM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) who both indicated the expectation for changing catheter bags and urinary leg bags would be to follow the facility's policy. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who receives nutrition and hydration and maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates otherwise for 1 of 4 residents (R19) reviewed for nutrition.Facility staff were aware R19 was prescribed a vegetarian diet and failed to provide a source of protein on his daily meal trays to accommodate R19's likes. R19 went 3 months without an adequate source of protein provided on his daily meal trays or a supplemental protein source R19 experienced a weight loss of 16%, a severe weight loss, in 3 months. Evidenced by:The National Council on Aging (NCOA) states, The first step in managing diabetes through diet as an older adult is to understand how different nutrients affect blood glucose levels. A balanced blend of high-fiber carbohydrates, lean protein, and healthy fats can help you maintain stable blood sugar levels and prevent dangerous fluctuations.it is recommended older adults consume 1.0-1.2 grams of protein per kilogram of body weight. For example, an older adult who weighs 150 pounds (68 kg) should eat 68-82 grams of protein per day. Aim to spread your protein intake evenly throughout the day with 20-30 grams at mealtimes and 12-15 grams with snacks.The Cleveland Clinic states that sarcopenia is the gradual loss of muscle mass, strength and function. The condition commonly affects the elderly population and is thought to occur due to aging. Sarcopenia can greatly impact quality of life by reducing the ability to perform daily tasks. Risk factors include malnutrition or inadequate protein intake. Sarcopenia can be treated and by increasing protein intake through food or supplements and aiming for 20 to 35 grams of protein in each meal.A 2023 study, titled Association of Dietary Patterns and Sarcopenia in the Elderly Population: A Cross-Sectional Study, states:*Due to the escalation of the reported prevalence in elderly populations, sarcopenia leads to a worse quality of life.* The results of this study showed that vegetarian participants had a higher risk of sarcopenia due to the insufficient protein intake of this dietary pattern.https://pmc.ncbi.nlm.nih.gov/articles/PMC10485369/ The facility's weights procedure policy staters, Residents will be weighed on admission and daily for the first 72 hours following admission. Weights will continue weekly for 4 weeks and monthly there in after or as needed as determined by a physician's order or nursing assessment of need. To assure proper assessment of residents' nutritional status, to monitor for changes in resident's health, to alert staff of potential problems that might be affecting residents health and wellbeing. Additionally, the policy states:*Any weight loss or gain of 5% of residents that are 101 lbs. or greater need to be reported to the physician.*Residents on alternate nutrition or deemed to be assessed at risk will be weighted weekly or as often as the physician or nursing assessment indicates. R19 was admitted to the facility from the hospital on 6/3/25 with diagnoses of cerebral infarction, type 2 diabetes, and congestive heart failure. His most recent MDS (Minimum Data Set), dated 9/8/25 includes a BIMS (Brief Interview for Mental Status) score of 15, indicating he is cognitively intact. R19 has a physician's order, dated 6/4/25, for a vegetarian diet, no dairy.R19's nutrition care plan states, Problem: Resident has potential for alteration in nutritional status related to diagnoses, medications, fluid balance, diet, intake, physical activity and metabolic demands.Goals: Maintain weight at a healthy range for the Resident without any unwarranted significant weight changes, tolerate physician ordered diet, have personal food and dining preferences met; promote and/or maintain skin integrity, and be without any s/s of any unfavorable nutrition outcome. There is no specific diet or dietary interventions documented on R19's care plan.R19's hospital discharge paperwork shows a weight of 228.3 lbs on 6/3/25. Facility records show the following weights:*6/3/25: 228.3 lbs*6/13/25: 206.2 lbs (Of note, this is a 22.1 pound/9.68% weight loss in 10 days, this would be considered a<br><br>(continued on next page) |

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| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ingleside Manor | 407 N Eighth St<br>Mount Horeb, WI 53572 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | severe weight loss.)*6/22/25: 209.2 lbs*6/23/25: 192.6 lbs (this is a 16.6 pounds/7.93% weight loss in a day)(Of note: R19 lost 35.7 pounds/15.63% of his body weight in 20 days, this is a severe weight loss) A dietary note, dated 6/26/25 and noted by RD T (Registered Dietician) states, Initial Assessment: [AGE] year old male admitted for rehab and cares.confirms his appetite has been adequate since admit. Height: 72 weight: 192.6 pounds (6/23/25). BMI: 26.12 kg/m2 (overweight). Admit weight of 228 lb-questionable, as are 6/21/25 weight of 192.6 lb and 6/23/25 weight above. All other weights since admit showing 202-209 lb-will monitor, though do not believe significant changes have occurred.estimated needs: 1750-2187 kcal/day, 70-88g pro/day, 1ml fluid/kcal. Diet: Vegetarian/no dairy diet.The facility recorded the following additional weights for R19:*7/1/25: 197 lbs*7/29/25: 196.5 lbs*8/5/25: 198 lbs*8/19/25: 198.4 lbs On 9/7/25, R19 tested positive for COVID and was monitored through 9/16/25. A quarterly dietary note by RD T, dated 9/11/25, states, Appetite has been good since admission, 51-100% on average. However, COVID+ currently and intakes decreased because of it.weight: 198.4 lbs (8/19).Recommendations: 1) Ensure Clear (or equivalent) TID (three times a day) due to recent poor oral intakes due to covid infection. Would expect minor weight loss from covid/poor oral intake; however, expect appetite to bounce back once infection clears. Will continue to monitor and advise on changes to nutrition interventions quarterly. It should be noted that facility documentation shows R19 was only offered the supplement on 9/16/25 in which he consumed 1-25%. R19's next and most recent recorded weight at the facility was on 9/19/25 in which R19 weighed 190.2 lbs. Of note, the facility gathers resident food intakes for breakfast, lunch and dinner. Between 6/3/25 and 7/1/25, the facility documented 4 meals: 6/8 breakfast (26-50%), 6/13 dinner (26-50%), 6/20 dinner (46-50%) and 6/21 lunch (26-50%). Additionally, meal intakes were not documented between 7/1 and 7/8, between 7/10 and 7/15, 7/21, between 8/10 and 8/23, 9/7, 9/9, 9/12, 9/14, 9/17, 9/18, and 9/21. On 9/25/2025 at 11:49 AM Surveyor was observing the lunch meal in the dining room. When R19 entered the dining room, a dietary aide plating food stated to R19, I know you don't like meat, so we have sweet potato fries, mashed sweet potatoes, peas, wax beans . R19 then received a plate of a baked sweet potato, mashed sweet potatoes, peas and wax beans. At this time, Surveyor asked R19 at his table what his diet was. R19 stated he was a vegetarian and everybody in his family is a vegetarian. R19 stated that he is concerned that he is not getting enough protein. R19 stated he did not like fish, eggs, or dairy but he would eat a peanut butter and jelly sandwich, bean burgers, beans, meat analogs, and tofu. When asked if anybody at the facility had tried to find him replacements for meat, R19 stated, No. When asked if he believed staff would bring him a peanut butter and jelly sandwich if he asked, R19 indicated they would, but had not asked and staff had not brought him any substitutes since he had admitted to the facility.On 9/29/2025 at 2:42 PM, Surveyor interviewed DM S (Dietary Manager). DM S stated that she gets diet info from the admission nurse and they tell her what diets their primary care physician is recommending. DM S stated that at the admission care conference for each resident there is a sheet that she goes through including preferences and finds out what each resident likes and what they don't like and she puts it on their diet ticket. DM S also state that she did not know if R19's protein intake was being monitored or tracked in any way, such as if he was on a supplement or if he had requested any food items outside of mealtime such as a peanut butter sandwich. DM S stated that her cooks know R19 is a vegetarian. When it comes to how to replace the lost protein/meat items for each meal, DM S indicated that she refers to either the dietician or primary care physician in determining what specifically he (R19) needs in terms of protein. DM S indicated that when R19 was first admitted she did look up meat free alternatives but all she could find was a case of hundred burgers. DM S also indicated that when R19 was admitted he was supposed to be short term<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | rehabilitation so some of the food ordering and attention to his dietary needs did not get immediate attention. Additionally, DM S stated that R19 would not drink a clear supplement because those still had milk-based ingredients, even though they were lactose-free. When asked if there were any plant-based supplements, DM S stated that she was unaware of such supplements. At approximately 3:15 PM, DM S approached Surveyor in the hallway with a plant-based Ensure supplement and stated she did not know such a supplement existed but found one in her kitchen and would offer it to R19.A dietary note by DM S, dated 9/29/25 at 3:34 PM states, Conversation with resident regarding diet and increasing protein and preferences. Upon admission in June, resident stated to me that he does not like eggs. Today, he retracted that statement saying that he will eat hard cooked eggs, egg salad, and the occasional scrambled egg. Offered resident a Plant Based Ensure to try. He said, Well, I am not familiar with that product. Encouraged resident to try it, and I would check back in with him to see if he liked it. Resident hesitant, but agreed. I also discussed meat alternative products with resident. Told resident that I would do some research to see what my supplier carries and then touch base with him tomorrow, 9/30, on those items, and the outcome of the Plant Based Ensure Trial. Note: dietician had recommended Boost Clear, however that contains milk product and resident was not interested. Email sent to nurse practitioner to request an order for the Plant Based Ensure if resident is agreeable to it.On 9/30/25 at 1:30 PM, Surveyor interviewed RD T who stated that when the facility most likely used the hospital weight on 6/3/25 instead of obtaining their own weight and should have gotten weights daily at the facility for 3 days and not waited until 6/13/25 to obtain a second weight. RD T indicated that the weights she had in her system were what Surveyors could see in the facility's EHR (Electronic Health Record). RD T stated that she wouldn't necessarily recommend any protein options for a vegetarian if the resident was eating well and that plenty of protein can be obtained from non-meat items and stated that she did not recommend any replacements for R19, nor was she tracking or monitoring his protein intakes. RD T indicated that being a vegetarian wouldn't be a red flag that a resident is malnourished and that it is more important to look at the intakes. RD T stated that she recommended ensure clear when R19 had COVID but was unaware that he would not take it and did not follow up with him or facility staff to see if he was taking the supplement. RD T stated, I would expect that the dietary manager would determine what a resident would eat and not eat. I try to default to the facility as they are available every day to the residents. RD T indicated that she had not recommended any other supplements for R19 other than the Ensure Clear.On 10/01/2025 at 8:54 AM, Surveyor interviewed DON B (Director of Nursing). DON B stated she was also concerned about R19's protein needs given his vegetarian diet and that his preferences should be met and obtained by the dietary manager. DON B stated that the facility and facility staff should be providing R19 with a protein replacement and that he should not have to ask them for alternatives. DON B also indicated that the facility should be doing weights more frequently for R19 given his steady weight loss.On 10/01/2025 at 9:12 AM, Surveyor interviewed DM S who stated that she had received the necessary order from the nurse practitioner to get R19 the plant-based ensure. DM S stated that she had just talked to R19 about other foods and R19 replied to bring him a list of possible food options and they could go through them together. DM S stated that she talked to R19 about peanut butter so she added peanut butter toast to his breakfast and made a list of beans for staff to be available to him. DM S stated that she now has a list of things R19 will eat. DM S stated that she should have made these changes when R19 was admitted and stated, What I should have done was asked him about how to fill the protein void when he came in. I didn't know until the next day after he was admitted that he was a vegetarian. DM S stated that she does not have a vegetarian alternative on the menu but will work with<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | providing other protein dense non-meat food items for R19 and other future vegetarians.On 10/1/25 at 3:15 PM, Surveyor observed a Diet Roster list posted on a refrigerator in the main kitchen which stated NO MEAT, EGGS OR DAIRY by R19's name. Next to this list was a Beverage Preferences list and next to R19's name it stated, OJ and milk for breakfast.The facility was aware that R19 was a vegetarian but did not care plan or put resident-specific interventions in place to address his preferences, needs for alternatives or any potential supplementation to meet the nutritive needs that had been assessed for him (70-88 grams of protein per day). The facility was not consistently monitoring R19's intakes, did not weigh R19 upon admission and for 10 days thereafter, and did not put any additional weights or interventions into place when R19 had been found to have experienced a 16% weight loss in 3 months. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**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 4 errors out of 31 opportunities that affected 2 out of 6 residents (R16 & R54) included in the medication pass task, which resulted in an error rate of 12.9%. R16's ordered Miralax was omitted. R16 received Simethicone without an order and received 2 tablets of Senna Plus and order was for 1 tablet. R54 was to receive 2 tablets of Senna Plus and it was omitted. Evidenced by:The facility policy entitled Medication Errors, dated 9/01/10, states, in part: . Applicability: This section 10.1 sets forth procedures relating to medication errors.Procedure: .4. Administration Errors: . Examples of administration errors include, but are not limited to: .4.4 Dose Error: Community administers to the resident a medication dose that is greater than or less than the amount ordered by the physician/prescriber.4.7 Omission Error: Community fails to administer an ordered dose to the resident.4.11 Unauthorized drug error: Community administers a medication dose not authorized for the resident. The facility policy entitled Administering Medications, dated 4/2019, states, in part: . Policy Statement: Medications are administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation: .4. Medications are administered in accordance with prescriber order. Example 1: R16 admitted to the facility on [DATE] and has diagnoses that include constipation and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone. Common symptoms of hypothyroidism include constipation.). R16's Care Plan dated 7/15/24, states, in part: . Problem: Category: Dehydration/Fluid MaintenanceR16 has constipation episodes.Approach:Approach Start Date: 7/15/24 Administer medications/enemas/suppository. R16's Physician Orders as of 9/30/25 include:-Miralax (polyethylene glycol 3350) powder; 17 grams/dose.Special Instructions: Constipation. Twice a day; 8:00AM 4:00PM. Start Date: 9/08/25. End Date: Open Ended. -Senna Plus (sennosides-docusate sodium) tablet, 8.6-50 mg(milligrams), amount 1 tablet, oral. Special instructions: Constipation Twice a day; 8:00AM, 8:00PM. Start Date- 9/09/25. End Date- Open Ended. Important to note: order is for 1 tablet.Important to note: Physician orders do not include an order for simethicone. R16's MAR (Medication Administration Record) for September 29, 2025, shows:-polyethylene glycol 3350 powder; 17 grams/dose was administered for 4:00PM dose-Senna Plus (sennosides-docusate sodium) tablet; 8.6-50 mg; Amount to administer: 1 tablet; oral, was administered for the 4:00PM dose. Important to note: 2 Senna Plus tablets were administered. On 9/29/25, at 4:00PM, Surveyor observed LPN J (Licensed Practical Nurse) administer to R16 2 Senna Plus tabs and Simethicone 80 mg chew tab. Important to note: Surveyor did not observe LPN J administer R16's Miralax that was ordered for 4:00PM. On 9/30/25, at 10:35AM, Surveyor interviewed DON B (Director of Nursing). Surveyor informed DON B of observation of LPN J administering to R16:-2 senna plus tabs-simethicone 80 mg chew tabSurveyor asked DON B when LPN J administered 2 tablets of senna plus when the order is for 1 tablet would that be a medication error. DON B indicated yes. Surveyor asked when LPN J administered simethicone without an order, would that be considered a medication error. DON B indicated yes. Surveyor asked DON B LPN J omitting Miralax and signing it out on the MAR without administering it, would that be a medication error; DON B indicated yes. DON B indicated she would expect physician orders to be followed. Example 2: R54 admitted to the facility on [DATE] and has diagnoses that include constipation. R54's Physician Orders as of 9/30/25, state, in part: . Start Date: 2/19/24. End Date: Open Ended. Senna Plus (sennosides- docusate sodium) tablet; 8.6-50 mg (milligrams), amount 2 tablets, oral. Twice a day; 8:00AM, 4:00 PM. R54's MAR (medication administration record) for 9/29/25 includes:-Senna Plus (sennosides-docusate sodium) tablet; 8.6-50 mg; Amount to Administer: 2 tablets, oral.Important to note: Order is for 2 tablets. On<br><br>(continued on next page) |

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| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 9/29/25, 4:06PM, Surveyor observed LPN J (Licensed Practical Nurse) administer Senna Plus 1 tablet to R54. On 9/30/25, at 4:36 PM, Surveyor interviewed DON B (Director of Nursing) and informed her of observation of LPN J administer R54 1 Senna Plus and order is for 2 Senna Plus. Surveyor asked DON B if this is a medication error and DON B indicated yes. DON B indicated she would expect physician orders to be followed. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. This affected 1 of 2 medication carts.<br><br>Surveyor observed medication on top of an unsupervised medication cart in hallway while nurse administered medications to a resident. The medication cart had an expired open bottle of Milk of Magnesia (laxative medication).<br><br>Evidenced by:<br><br>The facility policy entitled Administering Medications, dated 4/2019, states, in part: .<br><br>Policy Statement: Medications are administered in a safe and timely manner, and as prescribed.<br><br>Policy Interpretation and Implementation: .<br><br>19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.<br><br>The facility policy entitled Storage and Expiration Dating of Medications and Biologicals, dated [DATE], states, in part: .<br><br>Applicability: Policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes, and needles.<br><br>Procedure: .<br><br>10. Facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier<br><br>11. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guideline with respect to expiration dates for opened medications.<br><br>Example 1<br><br>On [DATE], at 4:06 PM, Surveyor observed MT K (medication tech) leave a stock bottle of Senna Plus, a stock bottle of AREDS (PreserVision), and a medication cup with 1 loose senna plus tablet on top of the medication cart unattended as MT K and Surveyor went into a resident's room to administer medications. The medications on the cart were left unattended for 5 minutes.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The medication cart was left in hallway, and the resident's door was closed, with the cart out of sight.<br><br>On [DATE], at 4:36PM, Surveyor interviewed MT K and asked if the stock bottle of Senna Plus and AREDS, and medication cup with the 1 loose Senna Plus tablet should be left unattended on top of the medication cart. MT K indicated no, it should have been locked in the medication cart. MT K put the 2 bottles and medicine cup with 1 senna plus tablet in the medication cart.<br><br>On [DATE], at 10:52 AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated medications should not be left on top of the medication cart unattended while MT K was administering medications in a resident's room with the door closed. DON B indicated she would expect the medications to be locked in the medication cart while unattended.<br><br>Example 2<br><br>On [DATE] at 8:59 AM, Surveyor observed the [NAME] Hall medication cart with LPN F (Licensed Practical Nurse). Surveyor observed an open bottle of Milk of Magnesia (laxative medication) marked with an expiration date of 7/2025. Surveyor interviewed LPN F regarding the bottle. LPN F stated that the medication was expired and should not be in the medication cart.<br><br>On [DATE] at 9:50 AM, Surveyor interviewed DON B (Director of Nursing) and asked about expiration dates. DON B stated the nurses and DON check the medication storage room for expiration dates and the nurses should be checking the medications in the cart. DON B stated that this outdated medication should not have been in the medication cart. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observation, interview, and record review, the facility did not provide food that accommodates resident preferences; appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice for 1 of 18 sampled resident's (R19). R19 was known to be a vegetarian and was not given foods of similar nutritive value to replace the meat options on the menu to maintain his assessed protein goals.Evidenced by:R19 was admitted to the facility from the hospital on 6/3/25 with diagnoses of cerebral infarction, type 2 diabetes, and congestive heart failure. His most recent MDS (Minimum Data Set), dated 9/8/25 includes a BIMS (Brief Interview for Mental Status) score of 15, indicating he is cognitively intact. R19 has physician's orders, dated 6/4/25, for a vegetarian diet, no dairy.R19's nutrition care plan states, Problem: Resident has potential for alteration in nutritional status related to diagnoses, medications, fluid balance, diet, intake, physical activity and metabolic demands.Goals: Maintain weight at a healthy range for the Resident without any unwarranted significant weight changes, tolerate physician ordered diet, have personal food and dining preferences met; promote and/or maintain skin integrity, and be without any s/s of any unfavorable nutrition outcome.There is no specific diet or dietary interventions documented on R19's care plan, nor what his likes and dislikes are.On 9/25/25 at 11:49 AM, R19 was observed sitting in the dining room. A dietary aide who was serving food asked R19 what he wanted to eat and stated, I know that you don't like meat. R19 acknowledged this and received a plate containing a baked sweet potato, mashed sweet potatoes, wax beans and peas. At this time, Surveyor asked R19 at his table what his diet was. R19 stated he was a vegetarian and everybody in his family is a vegetarian. R19 stated that he is concerned that he is not getting enough protein. R19 stated he did not like fish, eggs, or dairy but he would eat a peanut butter and jelly sandwich, bean burgers, beans, meat analogs, and tofu. When asked if anybody at the facility had tried to find him replacements for meat, R19 stated, No. When asked if he believed staff would bring him a peanut butter and jelly sandwich if he asked, R19 indicated they would, but had not asked and staff had not brought him any substitutes since he had admitted to the facility.On 9/29/2025 at 2:42 PM, Surveyor interviewed DM S (Dietary Manager). DM S stated that she gets diet info from the admission nurse and they tell her what diets their primary care physician is recommending. DM S stated that at the admission care conference for each resident there is a sheet that she goes through including preferences and finds out what each resident likes and what they don't like and she puts it on their diet ticket. DM S also state that she did not know if R19's protein intake was being monitored or tracked in any way, such as if he was on a supplement or if he had requested any food items outside of mealtime such as a peanut butter sandwich. DM S stated that her cooks know R19 is a vegetarian. When it comes to how to replace the lost protein/meat items for each meal, DM S indicated that she refers to either the dietician or primary care physician in determining what specifically he (R19) needs in terms of protein. DM S indicated that when R19 was first admitted she did look up meat free alternatives but all she could find was a case of hundred burgers. DM S also indicated that when R19 was admitted he was supposed to be short term rehabilitation so some of the food ordering and attention to his dietary needs were did not get immediate attention. Additionally, DM S stated that R19 would not drink a clear supplement because those still had milk-based ingredients, even though they were lactose-free. When asked if there were any plant-based supplements, DM S stated that she was unaware of such supplements. At approximately 3:15 PM, DM S approached Surveyor in the hallway with a plant-based Ensure supplement and stated she did not know such a supplement existed but found one in her kitchen and would offer it to R19.A dietary<br><br>(continued on next page) |

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|---|---|---|---|
| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ingleside Manor | 407 N Eighth St<br>Mount Horeb, WI 53572 |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | note by DM S, dated 9/29/25 at 3:34 PM states, Conversation with resident regarding diet and increasing protein and preferences. Upon admission in June, resident stated to me that he does not like eggs. Today, he retracted that statement saying that he will eat hard cooked eggs, egg salad, and the occasional scrambled egg. Offered resident a Plant Based Ensure to try. He said, Well, I am not familiar with that product. Encouraged resident to try it, and I would check back in with him to see if he liked it. Resident hesitant, but agreed. I also discussed meat alternative products with resident. Told resident that I would do some research to see what my supplier carries and then touch base with him tomorrow, 9/30, on those items, and the outcome of the Plant Based Ensure Trial. Note: dietician had recommended Boost Clear, however that contains milk product and resident was not interested. Email sent to nurse practitioner to request an order for the Plant Based Ensure if resident is agreeable to it.On 10/01/2025 at 8:54 AM, Surveyor interviewed DON B (Director of Nursing). DON B stated she was also concerned about R19's protein needs given his vegetarian diet and that his preferences should be met and obtained by the dietary manager. DON B stated that the facility and facility staff should be providing R19 with a protein replacement and that he should not have to ask them for alternatives.On 10/01/2025 at 9:12 AM, Surveyor once again interviewed DM S who stated that she had received the necessary order from the nurse practitioner to get R19 the plant-based ensure. DM S stated that she had just talked to R19 about other foods and R19 replied to bring him a list of possible food options and they could go through them together. DM S stated that she talked to R19 about peanut butter so she added peanut butter toast to his breakfast and made a list of beans for staff to be available to him. DM S stated that she now has a list of things R19 will eat. DM S stated that she should have made these changes when R19 was admitted and stated, What I should have done was asked him about how to fill the protein void when he came in. I didn't know until the next day after he was admitted that he was a vegetarian. DM S stated that she does not have a vegetarian alternative on the menu but will work with providing other protein dense non-meat food items for R19 and other future vegetarians.On 10/1/25 at 3:15 PM, Surveyor observed a Diet Roster list posted on a refrigerator in the main kitchen which stated NO MEAT, EGGS OR DAIRY by R19's name. Next to this list was a Beverage Preferences list and next to R19's name it stated, OJ and milk for breakfast.The facility was aware R19 was a vegetarian but did not establish alternatives and preferences to meet resident needs. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 of 1 resident (R28) reviewed for hospice.R28's current hospice plan of care and visit notes were not available to facility staff.The facility did not designate a staff member to coordinate the plan of care with the hospice provider.This is evidenced by: The facility's Hospice Program policy, revised July 2017, states, in part: .9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions. 10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. 12. Our facility has designated (Name) and (Title) (blank) to coordinate car provided to the resident by our facility staff and the hospice staff. a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services. B. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family. D. Obtaining the following information from the hospice: 1. The most recent hospice plan of care specific to each resident. 13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. 14. The coordinated care plan will reflect the resident's goals and wishes, as stated in his or her advance directives and during ongoing communication with the resident representative, including: a. Palliative goals and objectives; b. Palliative interventions; c. Medical treatment and diagnostic tests. 15. The coordinated care plan shall be revised and updated as necessary to reflect the resident's current status including, but not limited to: a. Diagnosis; b. Problem list; c. Symptom management (pain, nausea, vomiting, etc.); d. Bowel and bladder care; e. Nutrition and hydration needs; f. Oral health; g. Skin integrity; h. Spiritual, activity and psychosocial needs; and i. Mobility and positioning R28 was re-admitted to the facility on [DATE] with diagnoses including, but not limited to, chronic heart failure (heart is not functioning properly), and failure to thrive (a decline resulting in weight loss and weakness).On 1/7/25 R28 was enrolled in hospice services.The facility did not have record of R28's PI (pressure injury) assessments and measurements. Upon Surveyor's request for the information, the facility contacted hospice to request this documentation.On 9/30/25 at 3:00 PM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A if there should be a current hospice plan of care and visit notes for R28's PI (pressure injury) assessments from January through March 2025. NHA A stated, yes. Surveyor asked if there should be a current hospice plan of care hospice binder for staff to reference. NHA A stated yes. NHA A stated, the facility was caring for R28's PI but NHA A stated, she can see there is a documentation gap. On 10/1/25 at 11:24 AM, Surveyor spoke with RN Hospice O (Registered Nurse). Surveyor asked RN Hospice O, does R28 have a hospice plan of care. RN Hospice O stated, yes, whenever there is an admission currently living at the facility, the facility will request it and hospice will send it to the facility. RN Hospice O stated the plan of care is always available to ask for. RN Hospice O stated, anytime the facility needs anything<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | they ask me or call our main triage number inquiring to have that done. RN Hospice O indicated the plan of care is always accessible to the facility. Surveyor asked RN Hospice O, does the facility needs to request the plan of care or is it automatically provided. RN Hospice O indicated, she does not know. Surveyor asked RN Hospice O, if she shares visit notes with the facility. RN Hospice O stated, she has access to MatrixCare. RN Hospice O stated, if it's a regular visit and wound care is not involved, she enters the visit into MatrixCare (electronic health record). RN Hospice O stated, if she is completing wound care she will fax the documents to the facility.On 10/1/25 at 11:32 AM, Surveyor asked RN P (Registered Nurse) R28's hospice plan of care. RN P stated, she was unable to locate R28's care plan in the binder on the nurse's station bookshelf and stated that each hospice service is handled differently. Surveyor asked RN P how hospice and the facility communicate. RN P stated, hospice checks in with the RN (Registered Nurse), SW (Social Worker), and CNA's (Certified Nursing Assistants). RN P stated hospice will let us know if they make any changes or notify us of new skin issues. Surveyor asked RN P is there a designated staff member to coordinate the plan of care with hospice? RN P stated no. R28's current hospice plan of care and visit notes were not available to facility staff until after Surveyor requested them and the facility does not have a designate staff member to coordinate with the hospice provider. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not identify issues to which quality assessment and assurance activities are necessary or develop and implement appropriate plans of action to correct identified quality deficiencies for 2 of 2 Residents (R28 & R4). The facility has failed to identify key areas of deficient practice and implement action plans to correct these deficient practices or identify areas needing improvement to develop, implement, monitor, and evaluate action plans to achieve specific goals to improve quality of care for Pressure Injury care and prevention.Evidenced by:The facility's Quality Assurance and Performance Improvement (QAPI) Program-Feedback, Data, and Monitoring policy, dated March 2020, states, in part: The QAPI program is based on the collection of information obtained from data, self assessment and systems of feedback. Information is collected, evaluated and monitored by the QAPI committee. 1. Information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI committee in order to identify problems that are high risk, high volume, or problem prone and to guide decisions regarding opportunities for improvement. 2. The QAPI process focuses on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice or resident autonomy, and on making a good faith effort to correct or mitigate these outcomes. 3. Systems and tools used to identify, collect and evaluate data from all departments to monitor performance indicators include, but are not limited to the following: a. Self-assessment tools: *ongoing facility assessment *monthly resident census data.b. Data collection tools: *monthly surveillance reports for quality of care indicators. 6. Corrective actions and performance improvement activities are initiated and monitored.The facility's QAPI Plan 2025, dated 7/8/2025, states, in part: .The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but are not limited to, customer service, care management. The QA&A (Quality Assessment and Assurance) Committee reports to the executive leadership and Governing Body and is responsible for: . 3. Developing and implementing appropriate plans of action to correct identified quality deficiencies. Performance Improvement Projects (PIP) Overall PIP Plan: Performance Improvement Projects will be a concentrated effort on a particular problem in one area of the nursing center or on a facility-wide basis. They will involve gathering information systematically to clarify issues or problems and intervening for improvements.PIP Determination Process: Areas for improvement are identified by routinely and systematically assessing quality of care and service, and include high risk, high volume and problem prone areas. Consideration will be given to incidence, prevalence, and severity of problems, especially those that affect health outcome.R28 was admitted to the facility with four (4) Stage 1 PI's. R28 was at risk for further PI development and had significant co-morbidities including idiopathic peripheral neuropathy (a type of nerve damage where the underlying cause is unknown), generalized weakness, and a fractured syloid process right radius (thumb). The facility failed to, complete a readmission skin assessment, failed to accurately complete all weekly wound assessments and measurements, failed to notify provider of changes to PI, failed to document turning and repositioning, failed to offload pressure, and failed to follow standards of practice during wound care resulting in cross contamination of R28's PI. R28 developed an Unstageable PI which deteriorated to a Stage IV (4) PI with osteomyelitis.R4 was admitted [DATE] without any pre-existing pressure injuries. Since admission, R4 has developed 4 pressure injuries. The pressure injury on his left heel was first identified 10/25/24 at a stage 2 and progressed to an unstageable pressure injury<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | by 2/3/25. The pressure injury on his right heel was first identified on 10/25/24 at a stage 2 and progressed to an unstageable pressure injury by 10/29/24. The pressure injury on his left lateral foot, or 5th metatarsal was identified 6/13/25 at a stage 2 and progressed to an unstageable pressure injury on 6/27/25 (100% eschar wound bed with undetermined depth). The pressure injury on his left lateral foot was identified 9/15/25 as and unstageable pressure injury. R4 was diagnosed with cellulitis (skin infection) with a source of chronic left lateral malleolus (ankle) and left foot wounds on 6/16/25 that required IV (intravenous) antibiotics to treat. R4 was diagnosed with Group B strep bacteremia (bacterial infection in the blood) and left fifth metatarsal (where foot meets pinky toe) osteomyelitis (infection of the bone) which was treated with IV antibiotics with the only definitive recommended treatment being amputation. R4's initial pressure injury care plan was not put in place until 4/2025 and contained few interventions for pressure reduction/off-loading. R4 only had two Braden Scales for Pressure Injury Risk conducted since admission, which should have been completed upon readmission from the hospital and at least quarterly. R4 did not receive several wound treatments and missed several weekly wound assessments.On 10/1/25 at 2:39 PM, Surveyor interviewed ANHA C (Assistant Nursing Home Administrator) and asked how concerns are identified for QAPI. ANHA C stated through screening grievances, MDS (Minimum Data Set) flags / risks, interdisciplinary team meetings, employee surveys.On 10/1/25 at 4:32 PM, Surveyor interviewed ANHA C and asked if there had been discussion of and/or a PIP (performance improvement plan) initiated in relation to skin/Pressure Injuries. ANHA C stated no, not that I have been aware of. Surveyor asked if ANHA C would be aware of all topics discussed in QAPI. ANHA C stated, yes, he would be aware of all topics from 3/6/25 to present. ANHA C stated that there have been staff meetings with discussion of staff being the eyes (taking note of concerns), but there was no specific discussion of skin/PI. Surveyor asked if ANHA C was aware the facility had 2 residents with pressure injuries, one with a stage IV pressure injury and one with multiple stage 3 pressure injuries, ANHA C stated no. Surveyor asked if this was something that should have been discussed by QAPI. ANHA C stated, yes, ANHA C should have been made aware, and it should have been discussed by QAPI, as this is where the facility is best able to troubleshoot concerns.When adverse resident events are identified, the facility must analyze the cause of the error/event, implement corrective actions to prevent future events, and conduct monitoring to ensure desired outcomes are achieved and sustained, this was not initiated or completed by the facility for pressure injuries despite having residents with multiple pressure injuries that occurred in house or worsened after being admitted to the facility. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not establish and maintain 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 infection. This has the potential to affect the census (48). The facility is not monitoring the temperature of their water heater as part of their control measures for Water Management Program.The August 2025 line list does not include symptom monitoring. Evidenced by:The facility's Legionella Water Management Program policy, dated 9/2022, states, in part: Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella.5. The water management program includes the following elements: .e. Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; .h. A system to monitor control limits and the effectiveness of control measures; .j. Documentation of the program.Per Centers for Disease Control and Prevention (CDC), 3/15/24 documents, in part: .Cold water guidance: Store and circulate cold water at temperatures below 77 F, although Legionella may grow at temperatures as low as 68 F (20 C). Hot water guidance: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation doesn't fall below 120 F (49 C) and recirculate hot water continuously, if possible .The facility's Surveillance for Infections policy, dated September 2017, includes: The infection preventionist will conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment; b. available processes and procedures that prevent or reduce the spread of infection; c. clinically significant morbidity or mortality associated with infection; and d. pathogens associated with serious outbreaks. 4. Infections that may be considered in surveillance include those with limited transmissibility in a healthcare environment; and/or limited prevention strategies. 5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible.Data Collection and Recording .4. For targeted surveillance using facility-created tools, follow these guidelines: a. DAILY (as indicated): Record detailed information about the resident and infection on an individual infection report form.Example 1Surveyor requested documentation of monitoring of control limits in regard to water management. On 9/29/25 at 1:15 PM, NHA A (Nursing Home Administrator) provided the following documents and stated that temperature testing should be completed at least weekly, but these were the only documents that could be found:*TELS Report indicating temperatures dated 12/6/24: East Shower 109 F (Fahrenheit), East 62 110 F, South 84 111F, [NAME] 24 108 F, North 32 111F, Kitchen 110F*TELS Report indicating temperatures dated 4/7/25: Kitchen 140 F, Laundry 140 F, room [ROOM NUMBER] 110F, Shower room west 120 F, room [ROOM NUMBER] 130 F, room [ROOM NUMBER] 113 F*TELS Report indicating temperatures dated 4/8/25: laundry 120 F, Kitchen 120 F, North hall 108 F, west mixing valve 108 F, east hall 110 F, south hall 113 F*Ingle Living Communities Water Temps, dated 4/8/25: Boiler Rm Mixing Valve Temp--Linen 120, East 110, South 110; Administration Mixing Valve Temp--24 110,<br><br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Inglenook 108; Mech Rm Mixing Valve Temp-west 108, North 113, Dining room [ROOM NUMBER], kitchen 120 On 9/29/25 at 4:11 PM, Surveyor interviewed IP G (Infection Preventionist) who stated that the 3 documents from April were the only logs found for 2025. IP G stated the locations temped and listed on the documents are not all the areas that should be monitored, and all locations should be monitored weekly for water safety.On 9/30/25 at 12:58 PM, Surveyor interviewed MD E (Maintenance Director) who stated that the water at the boiler needs to be at 140 degrees, but MD E has not done any temperature testing since starting in September and MD E is not aware of any documentation of testing prior to arrival. Example 2The August 2025 Infection Surveillance Log includes the following:*R23 Start date 8/8/25 Levofloxacin (antibiotic) tablet 750mg (milligrams) 1 tablet daily for 4 days. Diagnosis (Dx): sepsis; start date 8/1/25 Bactrim DS tablet 800-160 mg 1 tablet twice a day. Dx: acute cystitis with hematuria (an inflammation of the bladder, typically caused by bacterial infection with bloody noted in the urine)*R4 Start date 8/29/25 amoxicillin (antibiotic) tablet 500 mg 1 tablet for GBS bacteremia suppression twice a day. Dx: bacteremia (bacteria in the bloodstream)*R8 Start date 8/18/25 valacyclovir (antiviral) tablet 1 gram oral three times a day. Dx: Shingles (a viral infection that causes painful rash)*R27 Start date 8/30/15 doxycycline hyclate (antibiotic) capsule 100 mg 1 capsule administer for 7 days for wound infection twice a day. Dx: venous insufficiency*R40 Start date 8/30/25 cefdinir capsule 300 mg once day. Dx: pneumonia (infection in the lungs)*R43 Start date 8/6/25 amoxicillin tablet 875 mg take with food for five days twice a day. Dx: cellulitis (a bacterial skin infection) of left lower limb*R46 Start date 8/9/25 cefuroxime axetil tablet 500 mg 2 tablets Take with food but do not start until blister fluid from top of foot has been collected. Twice a day. Dx: cellulitis*R47 Start date 8/13/25 cephalexin capsule 500 mg take with meals twice a day. Dx: Urinary tract infection*R5 Start date 8/27/25 cefdinir capsule 300 mg twice a day. Dx: urinary tract infection*R59 Start date 7/22/25 cefadroxil capsule 500 mg take 2 capsules by mouth 2 times daily for mealtime for 21 days for cellulitis. Dx: cellulitis; Start date 8/18/25 valacyclovir tablet 1 gram Take 1 tablet by mouth three times daily for 7 days for infection. Dx: ShinglesImportant to note: There was no documentation of symptoms of infection on the surveillance log. Surveyor asked for documentation of symptom surveillance; no further documentation was provided.On 9/25/25 at 9:44 AM, Surveyor interviewed RN H (Registered Nurse) and asked about residents with infection. RN H stated that residents with new symptoms should be monitored with vital signs for 3 days. RN H stated that RN H didn't think there was a 24 hour board at the facility, but that a progress note should be written and information shared in report to the next shift. RN H stated that residents with infection should have a progress note with resident assessment through the course of their antibiotic treatment.On 9/25/25 at 10:03 AM, Surveyor interviewed IP G (Infection Preventionist) and asked about surveillance of infection / symptom monitoring as there were no symptoms noted to be documented on the August 2025 Infection Surveillance Log. IP G stated the line lists that we gave you are not our expectation; we will be rolling out a new program October 1.On 9/30/25 at 3:21 PM, Surveyor interviewed IP G and asked about monitoring of residents on antibiotics. IP G stated that through the course of the antibiotic the resident should have an assessment of vital signs and the body system involved, along with any signs and symptoms of adverse reaction to the antibiotic. IP G stated that symptom surveillance had been a noted issue. On 10/1/25 at 9:50 AM, Surveyor interviewed DON B (Director of Nursing) and asked about surveillance of signs and symptoms of infection. DON B stated yes, signs and symptoms of infection should be monitored. DON B stated that DON B and IP G looked through all of their residents on 9/30/25 and created an up to date line list with symptoms and they would carry on with this process moving forward. Surveyor asked about residents on antibiotics. DON B stated that assessments<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525331 | A. Building<br>B. Wing | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ingleside Manor | 407 N Eighth St<br>Mount Horeb, WI 53572 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | should be done and documented through the course of the antibiotic. DON B stated it is the facility's plan to educate staff and make sure that this is occurring. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized for 2 of 5 residents (R9 and R2) reviewed for immunizations.R9 and R2 were not offered pneumococcal vaccination.Evidenced by:The facility's Pneumococcal Vaccine policy, dated 2001, states, in part: All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. 2. Routine vaccination consists of the following: a. If the resident has not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown: 1 dose of PCV15, 1 dose of PCV20, or 1 dose PCV21.d. Previously received only PPSV23: 1 dose PCV20, or 1 dose PCV21, at least 1 year after the last PPSV23 dose.4. Provision of information, education, and the VIS (Vaccination Information Statement) are documented in the resident's medical record. 5. The resident (or representative) has the right to refuse vaccines. If refused, the date of and stated reason for the refusal of the vaccine are documented in the resident's medical record.Example 1R9 admitted to the facility on [DATE].R9's Preventive Health Care Report lists Pneumococcal vaccines as follows:*Administration date: 11/20/2017 Type: PPSV23*Administration date: 6/10/2011 Type: PPSV23Per PneumoRecs VaxAdvisor, the U.S. Centers for Disease Control and Prevention's recommendation for R9's age group is to give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23.There is no documentation that R9 was offered a dose of PCV15, PCV20, or PCV21. Example 2R2 admitted to the facility on [DATE].R2's Preventive Health Care Report shows no documentation of Pneumococcal vaccines.Per PneumoRecs VaxAdvisor, the U.S. Centers for Disease Control and Prevention's recommendation for R2's age group is to give one dose of PCV15, PCV20, or PCV21.There is no documentation that R2 was offered PCV15, PCV20, or PCV21.On 9/29/25 at 4:11 PM, Surveyor interviewed IP G (Infection Preventionist) and asked about the facility's guidelines for offering the pneumonia vaccination. IP G stated that PneumoRecs app is used to determine if residents are up to date. Surveyor asked if R9 and R2 were up to date with their pneumonia vaccination. IP G stated no, they were not up to date and should have been offered vaccination at time of admission. |