STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525331	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingleside Manor	407 N Eighth St 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interviews, record review, and policy review the facility failed to notify hospice and the resident's representative timely with a change in condition for 1 of 12 sampled residents (R4). R4 had a change in condition evidenced by a change in her eating habits, this was not communicated to hospice or R4's representative. Findings include: Review of the facility's "Acute Condition Changes - Clinical Protocol" policy, revised February 2021, revealed, "Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, .) and how to communicate these changes to the Nurse." Review of the facility's "Change in a Resident's Condition or Status" policy, revised February 2021, revealed, "The nurse will notify the resident's attending physician or physician on call when there has been a(an): . significant change in the resident's physical/emotional/mental condition; . refusal of treatment or medications two (2) or more consecutive times; ." A "significant change" of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument." "Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: . there is a significant change in the resident's physical, mental, or psychosocial status; ." Review of R4's "Face Sheet" tab of the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE] and expired on [DATE]. R4 utilized hospice services and had diagnoses which included senile degeneration of brain, aphasia (difficulty speaking) and dysphagia (difficulty swallowing). R4's emergency contact was her family member (FM) 2. Review of R4's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [DATE], located in the EMR "RAI [Resident Assessment Instrument]" tab,f revealed the "Staff Assessment for Mental Status" indicated severely impaired cognitive skills for decision making. R4 had no swallowing disorder symptoms or weight loss. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Ingleside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 407 N Eighth St Mount Horeb, WI 53572	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's "Care Plan" located in the RAI tab of the EMR revealed the problem areas: -"at risk for dehydration r/t [related to] unable to voice needs and dependent with feeding/fluids" dated [DATE] with the approach to "allow resident to eat and drink as able, or as desired. Offer alternate and substitute items if needed." -dental care, dated [DATE], had an approach to "monitor food and fluid intake. Report decreased intake to appropriate clinician." -"requires hospice r/t senile degeneration of the brain," dated [DATE], with approaches to "Notify hospice when there is any change in the resident's condition" and "Communicate with hospice when any changes are indicated to the plan of care." Review of R4's EMR "Vitals" tab from [DATE] to [DATE] revealed no meal intakes documented except for 25% or less for breakfast on [DATE] and ,d+[DATE]% for breakfast and lunch on [DATE]. Review of R4's "Point of Care History" under the "Reports" tab of the EMR revealed an entry on [DATE] at 3:14 PM that R4 was unable to eat or drink anything for breakfast or lunch and staff reported she had been unable for two to three days. Review of R4's EMR "Progress Notes" tab revealed: -On [DATE] at 1:07 PM, "A staff member from therapy informed this nurse that the said resident has barely ate [sic] or drank anything in three days. I called [hospice] and someone will be here to visit the resident for further evaluation." -On [DATE] at 5:06 PM, hospice was at the facility and called to update family on the change. R4 left to go to the emergency room . -On [DATE] at 1:20 AM, R4 arrived back to the facility on two liters of oxygen to keep her comfortable because otherwise her oxygen levels drop. During an interview on [DATE] at 6:06 PM, FM2 reported the facility did not notify her that R4 had not eaten or drank for three days. FM2 confirmed being first updated when hospice called on [DATE]. FM2 stated because R4 had a similar reaction of not eating when she had an undiagnosed injury in the past, FM2 requested R4 be evaluated at the hospital, to rule out that versus an end-of-life change. During an interview on [DATE] at 12:00 PM, a Hospice Nurse, Registered Nurse (Hospice RN) 1 stated he was in the facility Monday through Friday and followed up on weekend phone calls on Mondays. Hospice RN1 could vaguely recall the facility reporting a decrease in appetite for R4. Per Hospice RN1's notes he accessed on his laptop, R4 had last been seen by a hospice nurse on [DATE] who recorded it was a routine visit without concerns or questions. On Monday, [DATE], when the Hospice RN1 was in the facility and followed up on weekend calls, R4 was placed on daily visits due to her change in status. Hospice RN1 expected to be contacted with a change such as not eating several meals, for a resident who normally ate. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 5:54 PM, Service Aide (SA) 1, a Certified Occupational Therapy Assistant, reported she assisted in the dining room during the day shift on [DATE]. SA1 recalled trying to get R4 to eat or drink, but she would not eat or drink, which was unusual for her. SA1 stated other staff talked about how R4 had not eaten for a few days; since this was a change the nurse should be aware of, if not already aware, SA1 relayed the change to the nurse. During an interview on [DATE] at 2:51 PM, Certified Nurse Aide (CNA) 3 stated R4 was unable to move on her own and did not talk. CNA3 stated R4 ate a lot, especially when FM2 assisted her. CNA3 stated R4 had remained the same for a long time and then abruptly stopped eating for two or three days before she went to the emergency room . CNA3 received report from CNAs that R4 was not eating and saw it himself. CNA3 was not sure if the nurses were aware that R4 was not eating since the facility had a lot of agency nurses who worked. CNA3 stated he would normally notify the nurse of a resident who was not eating, but he could not recall if he did in this instance. During an interview on [DATE] at 2:15 PM, the Director of Nursing (DON) stated if a resident was not eating or drinking, hospice and family were to be notified within a day. The DON questioned if R4 really did not eat for two or three days or if staff passed along information that was not accurate.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interview, record review, and facility policy review, the facility failed to ensure a resident-to-resident abuse allegation was reported to the administration and the State Agency within two hours for an allegation involving 2 of 12 sampled Residents (R1 & R2). An allegation of resident to resident abuse between R1 and R2 was not reported within the required timeframe. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022 revealed, 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 . 'Immediately' is defined as: within two hours of an allegation involving abuse . Review of the Face Sheet tab located in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE]. R1 had diagnoses including metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body.). Review of the Face Sheet tab located in the EMR revealed R2 was admitted to the facility on [DATE]. R2 had diagnoses including dementia and anxiety. Review of a State of Wisconsin Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report submitted to the Department of Health Services on 12/20/24 at 5:22 PM and supplied by the facility revealed R1 reported being backhanded in the face by another resident, R2. The report stated the event occurred on 12/19/24 around 7:30 PM and was discovered on 12/20/24. The report stated there were no known witnesses, a head-to-toe skin assessment revealed no injuries, and the resident did not report feeling unsafe. Investigation is ongoing. Review of the facility investigative file provided by the Assistant Administrator on 03/11/25 revealed the facility's former Admissions Director received an email on 12/20/24 from R1's family member (FM) 1 of an incident on 12/19/24, initially believed by FM1 to have been between a staff member and R1. The file stated when the Assistant Administrator interviewed R1, R1 reported R2 yelled at her, Your children are [NAME] along with other comments R1 could not recall as R1 tried to exit her room in her wheelchair. When R1 told R2 to get away from her, R2 backhanded R1 in the mouth. R2 then rammed her wheelchair into R1's wheelchair as R1 moved away from R2. R1 recalled the events occurring between 7:00 PM and 8:00 PM on 12/19/24 and reported she notified the Registered Nurse (RN) on duty who spoke to R2. When the Assistant Administrator interviewed R2, R2 could not recall any incident with R1. The Social Services Director (SSD) completed a Brief Interview of Mental Status (BIMS) on each resident on 12/20/24. R1 scored 10 out of 15, which indicated moderately impaired cognition and R2 scored 2 out of 15, which indicated severely impaired cognition. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided email from FM1 to the former Admissions Director revealed it was sent on 12/19/24 at 9:51 PM, and the former Admissions Director responded to FM1 on 12/20/24 at 10:53 AM, I am including [former Administrator] and [Assistant Administrator] on this. I have sent this to them for immediate review and personally let them know this concern. During an interview on 03/11/25 at 9:15 AM, R2 smiled and reported everyone at the facility was nice, and she had never hit anyone, nor had anyone ever hit her. During an interview on 03/11/25 at 12:25 PM, R1 reported R2 had rammed into the back of my wheelchair with her wheelchair. R1 could not recall if R2 touched her but did recall telling the nurse what had happened. R1 felt the nurse addressed it because she [R2] hasn't bothered me since. During an interview on 03/11/25 at 2:57 PM, FM1 stated she spoke to R1 each night. On 12/19/24, R1 told FM1 that a woman tried to get past her to use the phone and had backhanded her. R1 told FM1 she had told the staff. FM1 tried to call the facility but no one answered, and so she sent an email. During an interview on 03/12/25 at 4:10 PM, Certified Nurse Aide (CNA) 4 reported she had not witnessed R2 hit R1 when she worked the evening shift (2:00 PM to 10:00 PM) on 12/19/24. CNA4 recalled R1 reported to her on 12/19/24 that R2 had bopped her in the mouth, and CNA4 reported it immediately to the nurse (Registered Nurse (RN) 6). During an interview on 03/13/25 at 2:51 PM, CNA3 stated he did not witness R2 hit R1, but R1 reported to him on the evening shift on 12/19/24 that R2 hit her in the face. CNA3 stated he went right to the nurse to report the allegation. During an interview on 03/14/25 at 8:30 AM, the Assistant Administrator stated at the time of the allegation, she was primarily overseeing the non-nursing facility part of the building while the former Administrator oversaw the nursing facility, so she was not really involved in the reporting of the allegation. The Assistant Administrator reported as far as she knew, the facility was not aware of the allegation until the former Admissions Director read the email. The Assistant Administrator stated the timeframe for reporting an allegation of abuse was two hours. The Assistant Administrator stated families often emailed, which put us after the two-hour timeframe. The Assistant Administrator was unaware that staff had reported the allegation made by R1 to the nurse the night it occurred. RN6 was not available for interview during the survey. Cross-reference: F610

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interviews, record review, and facility policy review, the facility failed to interview all staff who may have had knowledge of a resident-to-resident abuse allegation involving 2 of 12 sampled Residents (R1 & R2). Facility did not thoroughly investigate a resident-to-resident abuse allegation involving R1 and R2. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised September 2022 revealed, All allegations are thoroughly investigated. The administrator initiates investigations . The individual conducting the investigation as a minimum: . interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . documents the investigation completely and thoroughly. Review of the Face Sheet tab, located in the electronic medical record (EMR), revealed R1 was admitted to the facility on [DATE]. R1 had diagnoses including metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body.) Review of the Face Sheet tab, located in the EMR, revealed R2 was admitted to the facility on [DATE]. R2 had diagnoses including dementia and anxiety. Review of a State of Wisconsin Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report submitted to the Department of Health Services on 12/20/24 at 5:22 PM and supplied by the facility revealed R1 reported being backhanded in the face by another resident, R2. The report stated the event occurred on 12/19/24 around 7:30 PM and was discovered on 12/20/24. The report stated there were no known witnesses, a head-to-toe skin assessment revealed no injuries, and the resident did not report feeling unsafe. Investigation is ongoing. The facility investigative file provided by the Assistant Administrator revealed the facility's former Admissions Director received an email on 12/20/24 from R1's family member (FM)1 of an incident on 12/19/24, initially believed by FM1 to have been between a staff member and R1. The file stated when the Assistant Administrator interviewed R1, R1 reported R2 yelled at her, Your children are [NAME] along with other comments R1 could not recall as R1 tried to exit her room in her wheelchair. When R1 told R2 to get away from her, R2 backhanded R1 in the mouth. R2 then rammed her wheelchair into R1's wheelchair as R1 moved away from R2. R1 recalled the events occurring between 7:00 PM and 8:00 PM on 12/19/24 and reported she notified the Registered Nurse (RN) on duty who spoke to R2. When the Assistant Administrator interviewed R2, R2 could not recall any incident with R1. The Social Services Director (SSD) completed a Brief Interview of Mental Status (BIMS) on each resident on 12/20/24. R1 scored 10 out of 15, which indicated moderately impaired cognition, and R2 scored two out of 15, which indicated severely impaired cognition. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the facility investigative file revealed the facility conducted interviews with staff asking if they had witnessed any resident being physically abusive toward another resident and if they knew who to notify if they witnessed or suspected abuse. None of the seven certified nurse aides (CNAs) or three RNs included in these interviews were on duty on the shift when the abuse allegation occurred. The facility investigative file contained an email the Assistant Administrator sent to the former Administrator on 12/20/24 at 5:33 PM regarding interviews she conducted with Certified Nurse Aide (CNA) 3 and CNA5 on 12/20/24. During the interviews, CNA3 stated he had not witnessed the incident but had heard CNA5 talking about it and heard that CNA4 saw the incident. CNA5 stated R2 had swung at her and CNA4 the evening before. CNA5 did not witness R2 swing at R1. The email stated, [CNA4] is an agency staff member. Her phone number is . if you would like to reach out. During an interview on 03/11/25 at 9:15 AM, R2 smiled and reported everyone at the facility was nice, and she had never hit anyone, nor had anyone ever hit her. During an interview on 03/11/25 at 12:25 PM, R1 reported R2 had rammed into the back of my wheelchair with her wheelchair. R1 could not recall if R2 touched her but did recall telling the nurse what had happened. R1 felt the nurse addressed it because she [R2] hasn't bothered me since. During an interview on 03/11/25 at 2:57 PM, FM1 stated she spoke to R1 each night. FM1 recalled on 12/19/24, R1 told FM1 that a woman tried to get past her to use the phone and had backhanded her. R1 told FM1 she had told the staff. FM1 tried to call the facility but no one answered, and so she sent an email. During an interview on 03/12/25 at 10:40 AM, the Assistant Administrator reported she had interviewed R1 and R2 as well as CNA3 and CNA5. The Assistant Administrator stated the former Administrator interviewed the other staff and residents. The Assistant Administrator was unable to verify if CNA4 had been contacted. During an interview on 03/12/25 at 4:10 PM, CNA4 reported she had not witnessed R2 hit R1. CNA4 recalled that on 12/19/24 the two residents had a verbal altercation and had been separated. R1 later reported to CNA4 that R2 had bopped her in the mouth, and CNA4 reported it immediately to the nurse [RN6]. CNA4 recalled R1 did not seem injured. CNA4 stated R2 had a history of wandering and being combative with staff who tried to redirect her. CNA4 stated no one from the facility had reached out to her regarding the incident. During an interview on 03/13/25 at 2:51 PM, CNA3 stated R2 went from really happy to really upset quickly for no known reason, but he did not believe R2 had ever hit another resident prior to 12/19/24. CNA3 stated he did not witness R2 hit R1, but R1 reported to him that R2 hit her in the face. CNA3 stated he went right to the nurse to report the allegation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/25 at 8:30 AM, the Assistant Administrator stated at the time of the allegation, she was primarily overseeing the non-nursing facility part of the building while the former Administrator oversaw the nursing facility, so she was not really involved in the investigation outside of assisting with the two resident and two staff interviews. She could not verify that any further staff interviews were conducted outside of the two she completed. The Assistant Administrator confirmed the investigation was not thorough. The Assistant Administrator stated she would have reached out to everyone on the schedule that shift as well as previous shifts, to find out more about what may have escalated any behaviors. Cross-reference to F609

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, interview, and facility policy review, the facility failed to administer medications as scheduled for 1 of 12 Residents (R3) reviewed for medication administration. R3's medications were documented as not being administered and/or documented as being administered late. Findings include: Review of the facility's Administering Medications policy, dated April 2019, revealed Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions and Medications are administered in accordance with prescriber orders, including any required time frame. In addition, Medications are administered within one hour of their prescribed time, unless otherwise specified. Review of R3's Face Sheet tab in the electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. R3 had diagnoses which included pulmonary hypertension, hypertension, and localized edema. Review of R3's quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 02/18/25, located in the EMR RAI [Resident Assessment Instrument] tab, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Review of R3's Medication Administration Record (MAR) located in the Reports tab of the EMR for the dates of 12/18/24 to 12/20/24 revealed the following orders: -hydralazine (vasodilator used to treat high blood pressure) 50 milligrams (mg) three times daily at 8:00 AM, 12:00 PM, and 4:00 PM -fexofenadine (antihistamine for allergies) 180mg daily at 8:00 AM -folic acid 1mg daily at 8:00 PM -liothyronine (thyroid medication) 25 micrograms (mcg) daily at 8:00 AM -losartan (blood pressure medication) 100mg daily at 8:00 AM -torsemide (diuretic) 10mg two tabs daily at 8:00 AM Review of R3's Medications Administration History report provided by the facility for the dates of 12/18/24 to 12/20/24 revealed: On 12/18/24 the 4:00 PM dose of hydralazine was documented as Not administered: Drug item unavailable. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 the 8:00 AM doses of fexofenadine and liothyronine were signed off as charted late at 1:24 PM; the 8:00 AM and 12:00 PM doses of hydralazine were charted late at 1:25 PM, and the 4:00 PM dose was signed off as late administration other on 12/19/24. The 8:00 AM doses of folic acid, losartan, and torsemide were signed off as administered late at 9:15 AM. On 12/20/24, the liothyronine and torsemide were documented as not administered: drug/item unavailable. Review of R3's Medication Administration Record (MAR), located in the Reports tab of the EMR, for the dates of 03/10/25 to 03/12/25, revealed the following orders: -carvedilol (blood pressure medication) 3.125mg twice a day at 8:00 AM and 4:00 PM -cephalexin (antibiotic) 500mg four times at 8:00 AM and 12:00 PM (course completed after noon dose 03/10/25) -fexofenadine 180mg daily at 8:00 AM -liothyronine 25mcg daily at 8:00 AM -torsemide 10mg two tabs daily at 8:00 AM Review of R3's Medications Administration History report provided by the facility for the dates of 03/10/25 to 03/12/25 revealed all 8:00 AM medications on 03/10/25 were signed off at 10:38 AM with the note late administration: administered late. The noon dose of cephalexin on 03/10/25 was given at 1:07 PM. All 8:00 AM medications on 03/11/25 were charted as late between 12:37 PM and 12:38 PM. During an interview on 03/12/25 at 2:15 PM, R3 reported getting medications late or occasionally having medications not available. R3 recalled concerns with medications on 12/18/24 and 12/19/24, and stated she received her 8:00 AM medications around 12:30 PM. R3 stated she received 8:00 AM medications well after 9:00 AM on 03/10/25 and 03/11/25. R3 reported occasionally having chest pain and having to ask for nitroglycerin when her blood pressure medications were not given on time, by 9:00 AM. During an interview on 03/14/25 at 2:15 PM, the Director of Nursing (DON), who was covering the floor, reported the expectation that medications are administered from an hour before until an hour after the scheduled time. The DON confirmed the late medication administrations.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview and record review, the facility did not ensure a medication error rate of 5% or less. During the medication administration task, Surveyors observed 18 errors out of 28 medication opportunities, resulting in an error rate of 64.28% This affected 3 out of 4 Residents (R) observed for medication administration (R10, R11 & R12). R10, R11 and R12 received their 8:00 AM medications more than an hour past their scheduled administration time. Evidenced by: Review of the facility's Administering Medications policy, dated April 2019, revealed Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions and Medications are administered in accordance with prescriber orders, including any required time frame. In addition, Medications are administered within one hour of their prescribed time, unless otherwise specified. Example 1: Review of R10's Face Sheet tab of the EMR revealed she was admitted to the facility on [DATE] and had diagnoses including end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, hypothyroidism and hypertension (high blood pressure). Review of R10's MAR for March 2025 revealed orders: - Aspirin 81mg (milligram) chew tablet once a day 8:00 AM - B complex tablet once a day at 8:00AM - Carvedilol 3.125mg tablet once a day sun, mon, wed, fri take 6.25mg on non-dialysis days Hold if systolic BP (blood pressure) is less than or equal to 120 or HR (heart rate) less than 60bpm (beats per minute) 8:00AM - Loratadine 10mg tablet once a day 8:00AM - Nifedipine 30mg extended release once a day on Sun, Mon, wed, fri on non-dialysis days in AM 8:00AM. - Omeprazole 20mg once a day 8:00 AM - Sertraline 25mg tablet once a day 8:00 AM - Sevelamer carbonate 800mg three times a day 8:00AM, 12:00PM, and 4:00PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER: Ingleside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 407 N Eighth St, 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Systane eye drops 0.4-0.3% (percent) once a day every other day place 2-3 drops into both eyes 8:00 AM - Vitamin D3 25mg (1000 unit) once a day 8:00AM - Levothyroxine 100mcg (micrograms) once a day 8:00 AM On 03/12/25, Registered Nurse (RN) 3 started preparing medications for R10 at 8:50 AM and administered them at 9:09 AM to R10. RN3 reported it was her second day at the facility, and she was behind on the medication pass when residents started lining up at the medication cart and talking. When asked how many more residents she had to administer 8:00 AM medication to, RN counted and responded, seven. (Of note: R10's medications were given at 9:09 AM, which is greater than an hour from the scheduled administration time) Example 2 Review of R11's Face Sheet tab of the EMR revealed she was admitted to the facility on [DATE] and had diagnoses which included diabetes and myopathy (muscle weakness and pain). Review of R11's quarterly MDS with an ARD of 01/06/25, located in the EMR RAI tab, revealed a BIMS score of 13 out of 15 which indicated intact cognition. Review of R11's MAR for March 2025 revealed orders: -Humalog insulin (a short acting insulin) 30 units with breakfast at 8:00 AM -Lantus insulin (a long acting insulin) 44 units twice daily at 8:00 AM and 8:00 PM -lidocaine adhesive patch 5%, apply to low back for pain at 8:00 AM and remove at 8:00 PM During an observation on 03/12/25 at 9:47 AM, Certified Nurse Aide/Medication Aide (CNA) 1 administered Lantus 44 units, Humalog 30 units, and a lidocaine patch to R11 in her room. No breakfast tray was observed. (Of note: R11's medications were given at 9:47 AM, which is greater than an hour from the scheduled administration time.) During an interview on 03/12/25 at 9:49 AM, R11 reported she had finished her breakfast, and she often received her morning medications around the current time. Example 3 Review of R12's Face Sheet tab of the EMR revealed she was admitted to the facility on [DATE] and had diagnoses including heart failure, pulmonary hypertension, anxiety, and hypertension (high blood pressure). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Ingleside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 407 N Eighth St 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R12's annual MDS with an ARD of 01/07/25, located in the EMR RAI tab, revealed a BIMS score of 11 of 15 which indicated moderately impaired cognition. Review of R12's MAR for March 2025 revealed orders: -bupropion HCl (antidepressant) 150mg daily at 8:00 AM -furosemide (diuretic) 20mg daily at 8:00 AM -lorazepam (anti-anxiety) 0.5mg twice a day at 8:00 AM and 8:00 PM -metoprolol tartrate (blood pressure medication) 25mg twice a day at 8:00 AM and 8:00 PM -vitamin B6 25mg 2 tabs daily at 8:00 AM -vitamin D3 2000 units daily at 8:00 AM During an observation on 03/12/25 at 10:10 AM, CNA1 administered R12's 8:00 AM medications except for the lorazepam and bupropion, which the resident refused. (Of note: R12's medications were given at 10:10 AM, which is greater than an hour from the scheduled administration time) During an interview on 03/12/25 at 10:15 AM, CNA1 stated medications were to be administered from an hour before to an hour after the scheduled time. CNA1 reported she started late and was pulled to do other things. During an interview on 03/12/25 at 10:20 AM. R12 stated she did not want to talk. During an interview on 03/14/25 at 12:10 PM, RN4 stated sometimes they did not have medications and had to keep on the out-of-town pharmacy to get the medications. The facility's contingency supply did not include some necessary medications and not all agency staff have access to it. RN4 reported there were times things like falls with frequent neurological checks or lab draws came up which made it difficult to administer all medications timely. RN4 focused on insulins and other time-sensitive medications if she was running behind. During an interview on 03/14/25 at 2:15 PM, the Director of Nursing (DON), who was covering the floor, reported the expectation that medications are administered from an hour before until an hour after the scheduled time. The DON confirmed the late medication administrations.