

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 06/10/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure a resident's safety during a transfer when one Resident (R1) of three residents reviewed for accidents sustained a minor injury after falling out of a Hoyer lift during a transfer.</p> <p>Findings include:</p> <p>Review of R1's Face Sheet, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure with hypercapnia.</p> <p>Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/07/25 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had no cognitive impairment.</p> <p>Review of R1's Care Plan, dated 01/29/24 and located in the resident's EMR under the Care Plan tab, revealed The resident has an ADL [activities of daily living] selfcare deficit due to impaired physical mobility. Interventions in place were resident required two staff using Hoyer lift for transferring.</p> <p>Review of R1's ED Provider Note with date of service 12/13/24. Resident arrived at hospital with concerns for fall from Hoyer lift with head strike. Findings revealed no intracranial abnormalities or fractures.</p> <p>During an interview on 06/09/25 at 8:40 PM R1 said sometime in December 2024 Certified Nursing Assistant 1 (CNA), and the Director of Nursing 2 (DON) were transferring her in the Hoyer lift and the sling she was in broke and she fell to the ground and hit her head. She remembers being sent to the hospital right after that.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/10/25 at 11:45 AM CNA1 stated some time ago within the last six months her along with DON2 were transferring R1 back into bed after she had been readmitted from the hospital. They were using the sling that was under R1 that she readmitted with from the hospital. She was operating the remote and DON2 was guiding R1. She was trying to move the machine to get R1 over the bed and as they moved her away from the wheelchair towards the bed, the back of the sling ripped, and R1 fell down. She was unsure of the distance to the floor or if R1 sustained an injury but she did not remember seeing any bleeding, but she thought R1 may have said she had a headache and she was sent out to the hospital.</p> <p>During an interview on 06/10/25 at 12:31 RN2 stated nothing was documented in the EMR about the fall. She said DON2 never documented anything, and that no documentation was completed related to the fall.</p> <p>During an interview on 06/12/25 at 6:12 PM DON2 stated she was the former DON but was no longer employed by the facility. She said in December 2024 R1 returned from the hospital and came back on a stretcher with a hoyer sling underneath her. She said she and CNA1 used the sling to transfer R1 back into bed and the sling ripped halfway and she lowered R1 to the floor and when R1 was just above the floor she fell and hit the floor. There were no visible injuries. She was unsure if she documented anything related to the fall in progress notes and she would have to check the facility policy to see if there was a requirement to document that the fall occurred. She was also unsure if she completed an incident report but that there should be a paper file alert that had the alerts to the physician and POA.</p> <p>During an interview on 06/10/25 at 3:52 PM the Administrator stated he was not the Administrator at the time this incident occurred and had no knowledge of it. He stated he looked and was unable to find any file or documentation related to it.</p> <p>Review of the facility's policy titled Safe lifting and Movement of Residents dated 2001 revealed, in order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. All equipment design use will meet or exceed guidelines and regulations concerning resident safety.</p>		