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	07/09/2025

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 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. Based on interview and record review the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 3 of 5 reportable incidents.R6 eloped from the facility on 6/6/25, this was not reported to the State Agency.R18 and R2 had a resident-to-resident altercation on //25, this was not reported to the State Agency.R18 and R19 had a resident-to-resident altercation on //25, this was not reported to the State Agency. On 6/30/25 at 9:15 AM, Surveyor interviewed CNA U (Certified Nursing Assistant). Surveyor asked CNA U about recent training on altercation between residents. CNA U indicated yes, you would deescalate the situation, separate the residents involved and redirect them, and report immediately. On 6/30/25 at 9:45 AM, Surveyor interviewed LPN L (Licensed Practical Nurse) and asked if she had received any training recently regarding resident-to-resident altercations. LPN L stated no. She had no training on resident altercations. LPN L did state that if there was an altercation between residents, she would in the future try to keep residents away from each other. Taking one resident down a different hall if the other resident was in that same hallway. To reduce chance of interaction between residents. On 6/30/25 at 4:03 PM RN J returned a phone call to Surveyor. Surveyor asked RN J (Registered Nurse) if she received any staff training regarding resident-to-resident altercations. RN J reported that she had training in April or May. She was previously given a flow sheet provided by the State of Wisconsin on Resident-to-Resident Altercations. She hung this up at the north west nurses station. RN J stated they have a 24-hour board they utilize for behaviors, falls, new meds, new orders, and out to the hospital. Residents are put on the board so the next shift is aware. RN J stated they are suppose to have more training, education at this months mandatory staff meeting.

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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(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. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations are thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken this affected 2 of 4 investigations (R18 and R2, R18 and R19) reviewed.There is no investigation for the resident-to-resident altercation between R18 and R2.There is no investigation for the resident-to-resident altercation between R18 and R19.This is evidenced by:The Facilities Policy and Procedure entitled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated September 2022 documents in part: .1. All allegations are thoroughly investigated. The administrator initiates investigations .4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation .7. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative. g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews other resident's roommate, family members, and visitors .k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly .Follow-Up Report 1. Within five (5) business days of the incident, the administrator will provide follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. 3. The follow-up investigation report will provide as much information as possible as the time of submission of the report. 4. The resident and/or representative are notified of the outcome immediately upon conclusion of the investigation .The Facilities Policy and Procedure entitled Resident-to-Resident Altercations dated September 2022, documents in part: . 2. Behaviors that may provoke a reaction by residents or others include: a. verbally aggressive behavior, such as screaming, cursing .4. If two residents are involved in an altercation, staff: a. separate the residents, and institute measures to calm the situation; b. identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation; c. notify each resident's representative and attending physician; d. review the events with the nursing supervisor and director of nursing services, and evaluate the effectiveness of interventions meant to address distressed behavior for one of both residents; e. consult with the attending physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; f. make any necessary changes in the care plan approaches to any or all of the involved individuals; g. document in the resident's clinical record all interventions and their effectiveness' h. consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team; i. complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record .Example 1R18's Progress Notes document the following:06/12/2025 05:30 PM Resident upset with staff member asking her if she threw cigarette butts on the ground, which she denied was her. Resident began shouting profanities down the hall. Resident went down another hall attempting to go confront another resident about the cigarette butts, staff intervened before coming near resident's room . 06/12/2025 06:30 PM [Recorded as Late Entry on 06/19/2025 01:13 AM]R18 was seen leaving her room following another resident down North Hall. This other resident was the resident that R18 previously attempted to confront on East Hall, before staff intervened. Writer placed herself on the R side of the resident to shield her, while asking R18 to return to her room. R18 began screaming and pointing finger at resident calling her a fucking bitch! and a fucking liar!, while attempting to reach around writer to get to resident. Writer pushed the other resident in her wheelchair towards the nurse's station for her safety, CNA took over care and escorted her outside, where she was heading prior to altercation. Additional CNA pushed R18 in her wheelchair back to her room. Writer called administrator and notified him of what occurred R2's

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/25 at 9:15 AM, Surveyor interviewed CNA U (Certified Nursing Assistant). Surveyor asked CNA U about recent training on altercation between residents. CNA U indicated yes, you would deescalate the situation, separate the residents involved and redirect them, and report immediately. On 6/30/25 at 9:45 AM, Surveyor interviewed LPN L (Licensed Practical Nurse) and asked if she had received any training recently regarding resident-to-resident altercations. LPN L stated no. She had no training on resident altercations. LPN L did state that if there was an altercation between residents, she would in the future try to keep residents away from each other. Taking one resident down a different hall if the other resident was in that same hallway. To reduce chance of interaction between residents. On 6/30/25 at 4:03 PM RN J returned a phone call to Surveyor. Surveyor asked RN J (Registered Nurse)if she received any staff training regarding resident-to-resident altercations. RN J reported that she had training in April or May. She was previously given a flow sheet provided by the State of Wisconsin on Resident-to-Resident Altercations. She hung this up at the north west nurses station. RN J stated they have a 24-hour board they utilize for behaviors, falls, new meds, new orders, and out to the hospital. Residents are put on the board so the next shift is aware. RN J stated they are suppose to have more training, education at this months mandatory staff meeting. On 7/2/25 at 4:23 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if all alleged violations should be thoroughly investigated, NHA A stated yes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the facility crash cart was checked by facility staff to ensure appropriate BLS (Basic Life Support) could be provided to any resident requiring such care prior to arrival of emergency medical personnel in accordance with current standards of practice for 2 of 2 crash carts with the potential to effect 34 of 34 full code (R) residents residing in the facility. The facility did not ensure the necessary supplies and equipment were readily available for residents of the facility who have chosen to receive basic life support if needed. Evidenced by:The facility was not able to provide a crash cart policy. On [DATE] at 11:22AM Surveyor interviewed LPN L (Licensed Practical Nurse). During the interview LPN L indicated that the crash cart was found to be locked during a recent incident when EMS (Emergency Medical Services) were in the building. LPN L indicated that she was walking down the hall with the DON (Director of Nursing) who told her EMS was asking for some type of clamp out of the crash cart and the DON stated she couldn't even get into the crash cart because it was locked. LPN L indicated the DON was going to the crash cart on [NAME] that services the North and [NAME] Halls. LPN L indicated it is currently locked and that no one has a key. LPN L indicated there is a second crash cart outside the ADON's (Assistant Director of Nursing) office on the corner of South and East Halls. LPN L indicated it is not locked but that there are no audit sheets on it, and she doesn't know the last time it was audited. LPN L indicated the night shift nurses are responsible for auditing the crash cart supplies. LPN L showed surveyor a sign on the South/East Halls nurses station bulletin board that indicates: Noc (Night) Nurses: Please audit the crash carts using the new supply audit. We will no longer use the old one. Audit happens every night on NOC (night) shift. If you are missing items in the crash cart, please leave a note in my box and we will work on replacing them immediately. Thank you. LPN L showed surveyor the crash cart for South and East Halls. The crash cart was unlocked. LPN L showed surveyor a binder on top of the crash cart that contained a document, titled, Crash Cart Supply Audit. The Audit is incomplete, with a start date of 1/23, and the following dates showing no check marks next to any of the supplies listed: 1/23, 1/24, 1/25, 1/27, 1/28, 1/29, 1/30, and 2/16. There are no dates listed for 2/3 - 2/7, 2/11 - 2/13, 2/18 - 3/1, 3/3- 3/9, and 3/11 - 3/14. There is no documentation on this form after [DATE] and no further audit sheets in the binder. The instructions at the bottom of the form indicate the following: To be completed each NOC-by-NOC nurse. Form to be turned into DON at the end of the month when complete. *Check expiration date or battery life. If anything is missing or expired replace if available, if not available notify Supply Person to order next day. On [DATE] at 12:09PM Surveyor interviewed LPN M and asked to be shown the crash cart she would use when working. LPN M took surveyor to a room she indicated was the North Hall Linen Closet (Of note, the linen room is on the [NAME] Hall near where the North and [NAME] Halls meet) and showed surveyor the crash cart located in this room. During the interview LPN M indicated she believed the crash cart is supposed to be checked by the nurses on night shift. Surveyor asked LPN M if she could open the crash cart. LPN M pulled on the drawers to the crash cart, and they would not open. LPN M indicated she could not open it without a key and proceeded to try multiple keys on her key ring and was not able to open the crash cart. LPN M indicated, This is kind of scary, why is this locked? Surveyor asked LPN M what she would do if there was a code. LPN M indicated she would call 911. Surveyor reviewed the binder on top of the crash cart that contained a document, titled, Crash Cart Supply Audit. The Audit is incomplete, with a start date of 1/23, and the following dates showing no check marks next to any of the supplies listed: 1/24, 1/25, 1/26, 1/28. There is no documentation on this form after 1/31. The instructions at the bottom of the form indicate the following: To be completed each NOC-by-NOC nurse. Form to be turned into DON at the end of the month when complete. *Check expiration date or battery life. If anything is missing or expired replace if available, if not available notify Supply Person to order next day.There was a second form in the binder titled, Daily Crash Cart Check, dated [DATE]. The only date completed is [DATE]th. Surveyor asked LPN M if the crash cart should be locked. LPN M indicated it should be accessible and that she shouldn't have a locked crash cart. Surveyor asked LPN M if she knew if there was another crash cart in the facility and she indicated she did not. On [DATE] at 1:04PM Surveyor interviewed ADON D. During the interview ADON D (Assistant Director of Nursing) indicated there are two crash carts in the facility and that nurses are expected to know where they are located. ADON D indicated that the night shift nurses should check them every night, the check list should be complete, and the crash carts should not be locked. Surveyor and ADON D observed the crash

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (R6) reviewed for elopement, 2 of 3 residents (R8 and R10) who smoke, 1 of 1 resident’s (R18) who voiced suicidal ideations, and 1 of 3 residents (R13) at risk for falls. The facility’s failure to supervise a resident who was known to be an elopement risk, created a finding of immediate jeopardy that began on [DATE]. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on [DATE] at 4:19 PM. The immediate jeopardy was removed on [DATE], however, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as evidenced by the following examples: R8 has no smoking assessment or care plan for smoking. R10 has no smoking assessment or care plan for smoking. R18 has no trauma assessment or care plan for suicidal ideations. R13 did not have fall interventions in place nor were fall interventions present on CNA (Certified Nursing Assistant) care cards. This is evidenced by: 1. The facility’s Policy and Procedure titled, “Wandering and Elopements” dated [DATE], documents in part: “…1. If identified as at risk for wandering, elopement, or other safety issues, the resident’s care plan will include strategies and interventions to maintain the resident’s safety…3. If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises, and c. If the resident is not located, notify the administrator and the director of nursing services, the resident’s legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.). 4. When the resident returns to the facility, the director of nursing services or charge nurse shall; a. examine the resident for injuries; b. contact the attending physician and report findings and conditions of the resident; c. notify the resident’s legal representative (sponsor); d. notify search teams that the resident has been located; e. complete and file an incident report; and f. document relevant information in the resident’s medical record. 5. When a resident requires a Wanderguard the facility will: a. Ensure a completed elopement risk assessment is in resident chart, b. Request order for Wanderguard from physician and update representative, c. Apply Wanderguard to resident ensuring the band is in a comfortable position, d. Add care plan for wandering to resident chart, e. Assess placement of Wanderguard twice daily…” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6 was admitted to the facility [DATE]. R6 has the following diagnoses: bilateral primary osteoarthritis of knee, dementia severity with other behavioral disturbance, type 2 diabetes mellitus with other diabetic kidney complication, abdominal aortic aneurysm without rupture, anxiety, major depressive disorder, OCD (obsessive compulsive disorder), emphysema, Crohn’s disease, chronic kidney disease stage 3a, and low vision (blind in L (left) eye, ocular obstruction R (right) eye). R6’s elopement assessment dated [DATE] documents the following: R6 is ambulatory, an elopement risk, has diagnosis that could contribute to elopement, history of wandering, and that an elopement care plan should be initiated. R6’s Elopement Care Plan was initiated on [DATE]. Wanderguard device was added to R6’s care plan on [DATE]. R6’s Progress Notes document the following: [DATE] 11:25 PM at approximately 1500 (3:00 PM) R6 was calm and cooperative in his room. By 1700 (5:00 PM) he became very restless, repeatedly asking staff for his car keys stating he needed to go home. He became very agitated and upset because the staff are not telling me the truth. His family tried calling him via face time on his tablet, his tablet was left at the nurses’ station. Upon his return to the nurses’ station, he was told that he missed a call from family. He stated he did not know the password to call the family back on the tablet. Writer and other staff showed R6 where his room was multiple times, but he did not believe it was his room. R6 began walking around the facility. Kitchen staff came to the nurses’ station to report R6 was found in the kitchen. Staff retrieved him and brought him back to his room. Staff offered snacks and beverages and redirected him multiple times. No medications were available to give for agitation. As of this time (2335) (11:35 PM) there are still no medications available since patient was admitted today. At approximately 1930 (7:30 PM) CNA staff took her break. She reported that while driving down the street she saw R6 walking on the side of the street. She picked him up in her car and returned him to the facility. Once CNA told writer of this, writer called … to inquire how to lock front doors to ensure that patient would not elope again. CNA called Administrator and described the above incident. Patient has been on Q (every) 15-minute checks and is now resting in bed as of 2334 (11:34 PM) [sic]. It is important to note that there was no documented set of vital signs or assessment upon R6 returning to the facility. Approximate distance that R6 ambulated was 0.4 miles. He was on the same side of the street as the facility and cemetery. [DATE] 03:07 PM Wanderguard placed to right wrist per resident high risk for elopement. Voicemail left for POA with update. It is important to note that there is no documentation of follow up monitoring after R6 eloped the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:41 AM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R to explain what happened on [DATE] when R6 eloped from the facility. CNA R explained that she was going on break somewhere between 8:00 and 9:00 PM, I know the sun was going down. I saw R6 was walking up the street toward Kwik Trip, R6 was walking in the street. CNA R stated R6 had just been admitted to the facility on [DATE]. CNA R stated the Therapist told staff R6 was a huge elopement risk, he kept trying to leave and saying he wanted to leave the facility. CNA R stated R6 was almost by the Kwik Trip near the end of the cemetery, CNA R state she told R6 to get in the car, he just got in my car, and I brought him back in the facility. Surveyor asked CNA R what the weather was like at the time. CNA R said it was nice out, warm but not humid. Surveyor asked CNA R if R6 was dressed for the weather and if he had shoes on; CNA R replied yes, his shoes were on, and he had on appropriate clothes. Surveyor asked CNA R what happened once you returned with R6, CNA R stated they put a Wanderguard on R6, he was placed on 15-minute checks I think, I updated NHA A and reported the event to the nurse and the CNA. On [DATE] at 10:56 AM, Surveyor interviewed LPN Q (Licensed Practical Nurse). Surveyor asked LPN Q if there is an elopement, what do you need to do afterwards; LPN Q stated this is all hands on deck- look for the resident, spread staff outside, notify DON (Director of Nursing) or whomever is on call and the NHA (Nursing Home Administrator). Check Wanderguard placement or place a Wanderguard to the resident’s wrist/leg, check function of the Wanderguard, complete vital signs and assess the resident. Document what the resident was wearing, is there a change in resident baseline, document the entire episode. If the resident is not found quickly, we should call the police, notify the family/POA (Power of Attorney), MD/NP (Medical Doctor/Nurse Practitioner). Surveyor asked LPN Q if the facility does not have a Wanderguard tab what would you do? LPN Q stated report this to the NHA A and assign someone to 1:1 with resident until NOC (night shift), once resident is sleeping, we would complete frequent checks of 15-minute checks during NOC. On [DATE] at 11:54 AM, Surveyor interviewed RN P (Registered Nurse). Surveyor asked RN P if the facility has an elopement, what do you need to do after the elopement occurs. RN P stated to update the DON, take resident’s vital signs, update the family/POA, and document the event in the progress notes. On [DATE] at 12:01 PM, Surveyor interviewed RN O. Surveyor asked RN O if there is an elopement in the facility, what do you need to do after the elopement occurs. RN O said get the resident’s vital signs, a head-to-toe assessment, notify the MD and DON. On [DATE] at 9:20 AM, Surveyor interviewed MT T (Medication Technician). Surveyor asked MT T if she had received any recent training on resident elopements. MT T indicated that she had training on what to do. MT T reported that she would stop what she was doing and look for the resident. 0n [DATE] at 9:50 AM, Surveyor interviewed LPN L (Licensed Practical Nurse) asking if she had received any training regarding elopement. LPN L reported that the facility had a quiz on elopement in the last two months. The quiz covered who gets notified. Surveyor asked LPN L what she would do if she found out a resident had eloped from the building. LPN L replied she would notify management, shut down everything, lock her med cart and start looking for the resident. In halls, bed checks, elevators. If not found after 30 min call 911 or local police. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:26 AM, Surveyor interviewed ADON D (Assistant Director of Nursing). Surveyor asked ADON D would you expect every resident that is an elopement risk to have a Wanderguard put on; ADON D stated yes. ADON D stated every resident who is identified as an elopement risk has their picture in an elopement book at nurses’ station and in the employee breakroom. We place orders for function and placement checks of the Wanderguard every shift in the TAR (Treatment Administration Record). We added in the computer system to have everyone check battery life of Wanderguards. Surveyor asked ADON D what would you expect your nurses to do after an elopement. ADON D said a full assessment, update the MD (Medical Doctor), update the POA (Power of Attorney), complete an incident report, and document the event in the progress notes. Surveyor asked ADON D would you expect there to be a set of vital signs, ADON D said yes. Surveyor asked ADON D if she would you expect there to be any type of assessment, ADON D replied yes, a head-to-toe assessment. Surveyor asked ADON D if she would you expect there to be follow up documentation after an elopement, ADON D replied yes. I would expect documentation of the episode, monitoring of residents for a few days after the event, an event report and investigation to follow the elopement. Surveyor asked ADON D what would you expect staff to do if a Wanderguard is needed but there are no Wanderguard tags available, or the tags are expired. ADON D stated the resident should then be 1:1 supervision. On [DATE] at 11:42 AM, Surveyor interviewed ADON D. Surveyor asked ADON D how are the expiration dates of Wanderguards being documented. ADON D said NHA A has list of activated dates and expiration dates. On [DATE] at 2:50 PM, Surveyor interviewed NHA A. Surveyor asked NHA A what the process would be for a late evening or weekend admission in relation to elopement process and care plan. NHA A said they would call on call nurse or manager to come in to put Wanderguard on and do the care plan. On [DATE] at 4:19 PM, Surveyor interviewed NHA A again. Surveyor asked NHA A what would you expect your nurses to do after an elopement. NHA A stated, reach out to MD, POA, myself, the DON, and complete incident report. Surveyor asked NHA A would you expect there to be a set of vital signs, NHA A said yes. Surveyor asked NHA A would you expect there to be any type of assessment, NHA A said yes. Surveyor asked NHA A would you expect there to be follow up documentation after an elopement, NHA A replied yes. Surveyor asked NHA A how the expiration dates of Wanderguards are being documented. NHA A explained that he has them set up on his calendar in his computer by serial number of devices, approximately 1 year after activation they expire so there is a week prior to this date set to remind him. Surveyor asked NHA A what you would expect staff to do if a Wanderguard is needed but there are no tags available or they are expired. NHA A stated they should reach out to me, resident will be placed on 1:1 until Wanderguard is applied. R6 was determined upon admission to be an elopement risk. The facility failed to implement interventions to ensure R6 received adequate supervision to keep R6 safe. R6 eloped from the building without staff being aware R6 left the facility. R6 was found walking down a busy street by a staff member. The facility’s failure to supervise a resident who is a known elopement risk created a reasonable likelihood for serious harm thus leading to a finding of Immediate Jeopardy. The facility removed the jeopardy on [DATE], however, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement the action plan below and as evidenced by the remaining examples: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Noncompliance: On [DATE] R6 was found by CNA walking down a nearby street to facility. Despite resident being assessed by admitting RN as being high risk for wandering/elopement, no measures were put into place to reduce the risk of resident leaving the facility unoccupied or without staff knowledge. Corrective Action: R6 put on 1:1 supervision immediately following incident on [DATE]. [DATE] NHA A reviewed status of Wanderguard system with staff. It was noted that potentially the current Wanderguard bands were expired and not alarming. Upon learning this, NHA A ordered new Wanderguard bands and placed staff 24/7 at exits until new bands were delivered to the facility and activated. [DATE] system was tested…and determined to be functioning. Exits still remained staff until wanderguard bands delivered to facility. [DATE] New Wanderguard bands delivered to facility. The NHA A activated bands and confirmed the function. Current residents with Wanderguards had bands replaced. The Elopement policy was reviewed and updated. Education started with staff on Elopement P/P (policy and procedure). On [DATE] education completed with remainder of staff on Elopement P/P finished up with staff. Corresponding quiz also completed by staff to determine competency of training. Facility TEL’s work order (facility system to place work orders) placed for monthly check to determine battery life of Wanderguard bands. Identification of other residents: [DATE] all residents had Elopement Risk Assessment completed to determine if any other residents at risk for elopement. All residents found to be at risk were care planned to reflect risk. Monitoring Performance: Beginning the week [DATE], NHA A or Designee to audit TELs 1x/week x 8 weeks to determine system testing for proper functioning of Wanderguard system. Beginning the week [DATE]: NHA A or Designee to monitor nursing has completed Q shift checks for Wanderguard battery lift 3x/week x 8 weeks, 2x/week x 4 weeks, 1x/week x 4 weeks. 2. The facility’s “Suicide Threats” Policy and Procedure dated [DATE], documents in part: “…1. Staff shall report any resident threats of suicide immediately to the nurse supervisor/charge nurse. 2. The nurse supervisor/charge nurse shall immediately assess the situation and shall notify the charge nurse/supervisor and/or director of nursing services of such threats. 3. A staff member shall remain with the resident until the nurse supervisor/charge nurse arrives to evaluate the resident. 4. After assessing the resident in more detail, the nurse supervisor/charge nurse shall notify the resident’s attending physician and responsible party and shall seek further direction from the physician. 5. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident’s behavior immediately. 6. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. 7. If the resident remains in the facility, staff will monitor the resident’s mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present. 8. Staff shall document details of the situation objectively in the resident’s medical record…” R18 is a short-term resident of the facility. R18 has the following diagnoses: psychosis, psychoactive substance abuse, borderline personality disorder, conversion disorder with seizures or convulsions, abnormal involuntary movements, intellectual disabilities, and anxiety disorders. R18’s most recent MDS (Minimum Data Set) dated [DATE] did not document a BIMS (Brief Interview for Mental Status) as it is documented that R18 would not answer the questions. It is documented under “C1000. Cognitive Skills for Daily Decision Making independent”. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R18 does not have a care plan for trauma or suicidal ideations. R18’s Progress Notes document the following: On [DATE] 05:30 PM Resident upset with staff member asking her if she threw cigarette butts on the ground, which she denied was her. Resident began shouting profanities down the hall. Resident went down another hall attempting to go confront another resident about the cigarette butts, staff intervened before coming near resident's room. Resident shouted in hall, I just want to die. Writer wheeled resident to room and provided therapeutic communication and active listening. Writer asked resident if she had any thoughts of killing herself, no response. Writer repeated the question, no response. Writer asked resident if she had a plan to harm herself in any way, no response. Writer repeated the question, no response. Writer called for a CNA (Certified Nursing Assistant) to come in room and sit with resident while writer stepped out to call the administrator. On [DATE] 06:15 AM Administrator placed resident on 1 on 1 care with facility RA (Resident Aide) for evening due to behavioral episode. Per NHA A (Nursing Home Administrator) the above note was supposed to be corrected to the time of 6:15 PM not AM. On [DATE] 02:38 PM Resident was upset because they couldn't go to the parade on Sunday. They started making suicide comments. Saying, I just going to cut my throat, I don't want to live anymore, I'm just done with life, and I just want a sharp object. Staff was able to redirect her thoughts to a new topic on fixing cars and going to Walmart. But once the staff was saying they are going and saying bye. Resident mentioned that they are still upset about not going to the parade and wanted to hurt themself. Staff informed CNAs and Nurse about the residents’ [sic] comments and told them to keep a close eye on her and keep her mind distracted. It is important to note that there was no update to the DON (Director of Nursing), no notification to R18’s Provider or family, and no care plan was initiated. On [DATE] at 11:35 AM, Surveyor interviewed AD Z (Activity Director). Surveyor asked AD Z what he did after R18 made the suicidal statements. AD Z said he called NHA A, ADON D (Assistant Director of Nursing), and the DON, they directed me to inform R18’s Nurse and CNAs for monitoring her. Surveyor asked AD Z if he knew what nursing staff he reported this to, AD Z stated he was unsure of what CNA or Nurse was updated. On [DATE] at 11:45 AM, Surveyor interviewed CNA R. Surveyor asked CNA R if R18 had made any suicidal comments to her. CNA R said, I heard her telling her nurse “I want to die.” Surveyor asked CNA R if she knew what happened with R18 after that; CNA R replied they put her on a 24hr watch with a service aide (1:1). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:48 PM, Surveyor interviewed RN S (Registered Nurse). Surveyor asked RN S how she became aware that R18 had made suicidal comments. RN S stated, I was aware, I got her to calm down and had her with me. Surveyor asked RN S if she knew who reported the comments to her. RN S initially said she believed it was a CNA but then later she thought it was AD Z that told her. Surveyor asked RN S what she did with the information. RN S said she called ADON D (Assistant Director of Nursing) who instructed her to send R18 to the ER (Emergency Room) for evaluation. Surveyor asked RN S what the process is if a resident makes suicidal ideations. RN S explained that safety comes first so the resident can’t be left alone, update the NHA and DON, call family if applicable, notify Provider, obtain a set of vital signs, full assessment, and care plan should be done. On [DATE] at 4:01 PM, Surveyor interviewed ADON D. Surveyor asked ADON D what are your expectations if a resident makes suicidal ideations; ADON D replied, I may need to check the policy on that, but, don’t leave them, nurse should ask about a plan and details, ensure they are safe, not leave the patient alone, call their Provider, 1:1, and follow the policy. Surveyor asked ADON D would you expect there to be nursing documentation regarding suicidal ideations, ADON D stated yes. Surveyor asked ADON D how was R18 protected on [DATE] with further suicidal ideations. ADON D said she was sent to ER. Surveyor asked ADON D how it is decided when someone comes off 1:1 for suicidal ideations. ADON D replied, there’s a protocol, follow the policy, and discuss with Provider. Surveyor asked ADON D how long R18 was on 1:1 supervision on [DATE]; ADON D stated, I’d have to look. Surveyor asked ADON D would you expect there to be a care plan in place for suicidal ideations, ADON D stated yes. Surveyor asked ADON D would there be referrals for psych services, ADON D said yes, they have a service that comes to the facility. Surveyor asked ADON D what is your expectation of “keep a close eye on her and keep her mind distracted.” ADON D said she would need to verify what that means; role in Activities engage her more . Surveyor asked ADON D if R18 was on any type of monitoring upon return from ER on [DATE], ADON D stated no, she was better then, no further comments made. On [DATE] at 4:23 PM, Surveyor interviewed NHA A. Surveyor asked NHA A if he knew how long R18 was on 1:1 supervision on [DATE]; NHA A stated until the following day. Surveyor asked NHA A how was it determined that R18 could come off 1:1? NHA A replied that R18 hadn’t made any further comments. Surveyor asked NHA A who decided that R18 could come off 1:1; NHA A said it was an IDT (Interdisciplinary Team) discussion. Surveyor asked NHA A if he would expect there to be nursing documentation surrounding a resident making suicidal ideations, NHA A stated yes. Surveyor asked NHA A what is your expectation of “keep a close eye on her and keep her mind distracted?” NHA A said that is up for interpretation. Of note, ADON D was interviewed in place of DON B as during this survey DON B resigned. 3. R10 was admitted to the facility on [DATE]. Diagnoses include Unspecified fracture of L femur, abdominal aortic aneurysm, and repeated falls. R10's most recent Minimum Data Set (MDS) target date of [DATE], indicates a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R10 was cognitively intact. Surveyors asked for a list of smokers in the facility and R10 was among the residents on the list. R10 did not have a smoking assessment or a care plan related to smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:35 AM, Surveyor interviewed ADON D (Assistant Director of Nursing) who indicated she would expect residents who smoke to have a smoking assessment done and have a care plan related to smoking. 4. The facility policy, Smoking Policy - Residents, revision date of [DATE], includes, in part: .7. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. current level of tobacco consumption; b. method of tobacco consumption; c. desire to quit smoking; d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation) .10. Any smoking relating privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues . R8 was admitted to the facility on [DATE] with diagnoses that include in part: acute and chronic respiratory failure with hypoxia (condition in which the body is deprived of adequate oxygen), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the bloodstream), obesity, chronic osteomyelitis right ankle and foot (an infection of the bone that causes inflammation and pain), heart disease, congestive heart failure, hypertension, chronic obstructive pulmonary disease, depression, non-pressure chronic ulcer of right heel and midfoot, type 2 diabetes mellitus, and nicotine dependence. R8's most recent Minimum Data Set (MDS), target date [DATE], indicates a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating R8's cognition is moderately impaired. On [DATE], Surveyors requested a list of residents who smoke. R8 was one of the residents on the list provided by the facility. On [DATE] at 12:43 PM, Surveyor reviewed R8's Electronic Health Record and was unable to find a smoking assessment and did not see smoking on R8's comprehensive care plan. On [DATE] at 3:40 PM, Surveyor requested to see smoking assessments and smoking care plans for R8 and R10. DO V (Director of Operations) told Surveyor the facility does not have smoking assessments or care plans related to smoking for those residents. On [DATE] at 8:30 AM and 9:50 AM, Surveyor observed R8 outside smoking. Throughout the course of the survey, Surveyor observed R8 smoking outside several more times. On [DATE] at 8:35 AM, Surveyor interviewed CNA W (Certified Nursing Assistant) and asked what the process is if a resident wants to smoke. CNA W indicated she would verify with the nurse that the resident could smoke and escort them to the smoking area. CNA W indicated she would make sure resident didn't have oxygen on. On [DATE] at 8:40 AM, Surveyor interviewed RN E (Registered Nurse) who indicated residents have to be assessed when they first come in to determine they can smoke safely and how much assistance they need. RN E indicated cigarettes are kept in the med cart or medication room and residents are educated to not wear oxygen while smoking. RN E indicated she was unsure if smoking goes on the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:35 AM, Surveyor interviewed ADON D (Assistant Director of Nursing) who indicated she would expect staff to complete a smoking assessment and smoking care plan for a resident who smokes. 5. Facility policy titled, Falls and Fall Risk, Managing, revision date [DATE], states in part: . Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor (s) of falls for each resident at risk or with a history of falls .Monitoring Subsequent Falls and Fall Risk: .2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g. dizziness or weakness) has resolved .3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified . R13 was admitted to the facility on [DATE] with diagnoses that include in part: encephalopathy (brain disease that alters brain function or structure), Type 1 diabetes mellitus with diabetic polyneuropathy, schizoaffective disorder, repeated falls, weakness, shock, low back pain, moderate protein calorie malnutrition, alcohol dependence in remission, nicotine dependence, hypertension, congestive heart failure, acute respiratory failure with hypoxia, acute kidney failure, and mood affective disorder. R13's most recent MDS (Minimum Data Set) dated [DATE] states that R3 has a BIMS (Brief Interview for Mental Status) score of 14 out of 15, indicating R13 is cognitively intact. R3's most recent section GG, Functional Abilities and Goals, indicates that R13 is substantial assist for toileting and partial/moderate assistance for dressing and transfers. On [DATE] around 3:00 PM, Surveyor reviewed R13's care plan. R13's Comprehensive Care Plan states, in part: Problem start date: [DATE] Category: Falls - [Resident name] is at risk for falls due to weakness, encephalopathy. Last reviewed/revised: [DATE] Goal: Short Term Goal Target date: [DATE] - Resident will be free of falls. Approach start date: [DATE] - [Resident name] will have fall mats at bedside. *Of note, this approach does not specify when the mats should be at bedside. Approach start date: [DATE] - Implement exercise program that targets strength, gait and balance. Approach start date: [DATE] - Increase staff supervision with intensity based on resident need. Bed in lowest position. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Approach start date: [DATE] - Provide individualized toileting interventions based on needs/patterns. *Of note, throughout the survey, Surveyor did not observe a fall mat in R13's room. On [DATE] at 3:30 PM, Surveyor interviewed LPN Q (Licensed Practical Nurse) and asked her what R13's current fall interventions were. LPN Q stated they would be on the Kardex on R13's door. LPN Q indicated R13 had grippy socks and floor mats. At 3:43pm, LPN Q came up to Surveyor and stated the CNA (Certified Nursing Assistant) told her R13 doesn't use the mat anymore, doesn't know when she stopped using it. LPN Q indicated she put the mat down a laundry chute to be cleaned that day. On [DATE] at 3:35 PM, Surveyor interviewed CNA X (Certified Nursing Assistant) and asked about fall interventions for R13. CNA X stated R13 uses grippy socks, making sure call light is in place and within reach, 2 hour toileting schedule, and indicated R13 doesn't use the mat anymore and doesn't remember how long it's been since R13 stopped using the fall mat. On [DATE] at 9:10 AM, CNA X and Surveyor observed the Kardex in R13's room together and noted there were no fall interventions on this Kardex which was dated [DATE]. The only interventions on the Kardex in R13's room were Activities of Daily Living, Functional Status information. CNA X stated the fall interventions should be on there. In a follow up interview on [DATE] at 9:45 AM, CNA X indicated fall interventions are in the care plan and Kardex, she would check the Kardex first, and stated the date last updated should be on both. On [DATE] ar

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**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 assisted nutrition and hydration maintains acceptable parameters of nutritional status unless the resident's clinical condition demonstrates otherwise for 1 of 4 residents (R14) reviewed for nutrition and hydration.R14 has diagnoses including severe protein malnutrition, severe weight loss, and adult failure to thrive (FTT). R14 was admitted to the facility on [DATE]. R14's discharge physician orders included an order indicating NPO (Nothing by Mouth). R14 was to receive enteral feedings. (An enteral feeding, also known as tube feeding, is a method of providing nutrition directly into the gastrointestinal (GI) tract when a person cannot consume enough food or fluids orally.) R14's enteral feeding orders were not transcribed into the MAR (Medication Administration Record) resulting in R14 not receiving his enteral feeding from 6/27/25 until the staff recognized the transcription error on 6/30/25. On 7/1/25, R14 weighed 113 lbs. 7 oz. This is approximately a 12 lb. weight loss from the hospital weight of 125 lbs. 7.1 oz. recorded on 6/25/25. This is approximately a 9. 6% severe weight loss in 6 days.The facility's failure to ensure R14 received nutrition and hydration to maintain acceptable parameters of nutritional status, failure to recognize R14's enteral feeding orders were not transcribed into the MAR, and failure to ensure R14 received his enteral feeding and water flushes as ordered created a finding of immediate jeopardy that began on 6/27/25. Surveyor notified NHA A (Nursing Home Administrator) of the of the immediate jeopardy on 7/2/25 at 1:10 PM. The immediate jeopardy was removed on 7/3/25, however, the deficient practice continues at a severity/scope of D (potential for no more than minimal harm/isolated) as the facility continues to implement its action plan.This is evidenced by:The facility's policy titled Reconciliation of Medications on admission revised July 2017, states in part; the purpose of this procedure is to ensure medication safety accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. General Guidelines: Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medication by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages, routes, during the admission/transfer process. Medication reconciliation helps to ensure that all medications, routes and dosages on the list are appropriate for the resident and his/her condition and not interact in a negative way with other medications/supplements on the list. Medication reconciliation helps to ensure that the medications, routes, and dosages have been accurately communicated to the attending physician and care team. https://www.todaysgeriatricmedicine. com/archive/110310p8.shtml> states in part: FTT (Failure to Thrive) in older adults has been described as a syndrome manifested by weight loss greater than 5% of baseline, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol levels. It may result from issues such as chronic disease and functional decline, physical and emotional deprivation, poor appetite, poor diet, or medical problems. All of these combined can easily lead to inadequate food intake, malnutrition, unintended weight loss, weakness, functional decline, and other complicating factors such as falls, impaired immune response, and poor wound healing. FTT affects 5% to 35% of community-dwelling older adults and 25% to 40% of nursing home residents. Its prevalence appears to increase with age. Studies indicate that it is associated with decreased immunity and increased rates of infection, incidence of hip fractures, pressure ulcers, surgical mortality, mortality rates, and medical costs. FTT is not a normal consequence of aging or chronic disease, and caution should be used in applying the geriatric FTT label. It should not be treated as a diagnosis or a disease or equated with frailty, and it should not signal the withdrawal of efforts to find and treat underlying causes. Instead, it should be viewed as an unexpected and significant change in normal health status, a decline in vigor, weight, and function that can affect even the healthiest of older adults. For older patients exhibiting an unintended reduction of food intake, unintended weight loss, decline in the ability to provide self-care, a decline in cognitive function, and a general decline in interest in daily life, the term failure to thrive should trigger a thorough evaluation to determine possible reversible underlying causes. https://my.clevelandclinic. org/health/diseases/22987-malnutrition> states in part: one of the most common symptoms of FTT (failure

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents who receiving nutrition and medication by G-tube (Gastrostomy tube, a thin flexible tube inserted through a small incision in the abdomen and into the stomach, used to provide nutrition and fluids) receive the appropriate treatment and services 3 of 4 Residents reviewed for tube feedings (R15, R16 and R17).R15 has a G-tube (Gastronomy tube) is not being checked for placement prior to use.R16 has a G-tube that is not being checked for placement prior to use.R17 has a G-tube that is not being checked for placement prior to use. Evidenced by:Facility policy entitled 'Confirming Placement of Feeding tubes,' states in part: .The purpose of this procedure is to ensure proper placement of an existing feeding tube prior to administering enteral feedings or medication. Preparation 1. Verify that there is a physician's order for this procedure. 2. Verify that placement of the feeding tube was confirmed by x-ray upon initial insertion and that the tube has been marked or the tube length has been documented. 3. Review the resident's care plan and provide for any special needs of the resident. 4. Assemble equipment and supplies needed.To confirm placement of an existing feeding tube at the bedside: 1. The exit site of the feeding tube should be marked (by incremental marking on the tube or by documented tube length) at time of initial placement. 2. If a change in the incremental markings or tube length is observed, use additional method(s) to test whether the tube is properly positioned: a. observe for symptoms of elevated gastric residual volume (GRV): (1) a sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach; (2) little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus b. observe and check the PH of aspirate: (1) fasting stomach contents will have a clear and colorless or grassy green and brown appearance. (2) fluids from the pleural space may have a pale yellow, serous appearance. (3) post-pyloric/small bowel contents can be bile-stained, light to dark yellow or greenish-brown. (4) fasting stomach acid will have a pH of 5 or less.3. If the above suggests improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 4. When correct tube placement has been verified, flush tubing with at least 30 mL (milliliters) warm water (or prescribed amount).Documentation: The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data.Example 1R15 was admitted on [DATE] with diagnosis that include Multiple sclerosis, dysphagia, moderate protein-calorie malnutrition, esophagitis and encounter for surgical aftercare following surgery on the digestive system. R15's Care Plan indicates the following requires a tube feeding and oral diet to meet their nutrition and/or hydration needs to support their overall metabolic demands. Approach: administer tube feeding per MD (physician) orders. Provide diet, supplements, and/or medications as ordered. Provide assistance with meals as needed. Provide fluid flushes as ordered. Review for any complications of aspiration, tube dysfunction, or GI (gastrointestinal) intolerances.(Of note: there are no approaches/interventions listed for staff to check R15's tube placement or the length of R15's G-tube.) R15's Physician orders indicate:Flush 30 ml before giving Jevity and flush with 150ml after each bolus feeding; special instructions: flush 30ml before and after 150ml each Jevity carton four times a day (8am, 12pm, 4pm, 8pm)Free water flush 30ml before and after meds twice a day.Jevity 1.5 cal. (Calorie) (lactose-reduced food with fiber) liquid, 1 carton, give using gravity feeding bag, offer 1 carton two times daily at noon and bedtime if less than 50% of lunch or dinner.Jevity 1.5 cal. 2 cartons Nasogastric tube, using gravity feeding bag once daily in AM (8AM).Review of R15's June 2025 MAR (Medication Administration Record) and TAR (Treatment Administration Record) indicated no evidence of R15's G-tube placement being checked prior to water flushes, medications or tube feeding being administered. Example 2 R17 was admitted on [DATE] with diagnosis that include nontraumatic intracerebral hemorrhage, and Gastrostomy status.R17's Care Plan indicates the following: Resident requires a tube feeding and oral diet to meet their nutrition and/or hydration needs to support their overall metabolic demands. Approach: administer tube feeding per MD order. Provide diet, supplements and/or medications as ordered. Provide assistance with meals as needed. Provide fluid flushes as ordered. Review for any complications of aspiration, tube dysfunction or GI intolerances.(Of note: there are no approaches/interventions listed for staff to check R17's tube placement or documentation of the

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to complete a performance review of every nurse aide at least every 12 months and failed to provide regular in-service education based on the outcome of these reviews for 5 of 5 staff for evaluations and 4 of 5 staff for education.All 5 staff chosen did not have performance evaluations completed every 12 months.Four of five staff did not have regular in-service education completed every 12 months.This is evidenced by:The Facility's 5.6 Performance Evaluation/Review Policy from the Employee Handbook, undated, documents in part: Performance evaluations/reviews are generally scheduled once a year based on the employee's anniversary date or upon change in assignments The Facility does not have a Policy or Procedure specific to required in-service education.In Wisconsin, CNA's (Certified Nursing Assistants) are required to complete 12 hours of continuing education annually. This requirement is part of maintaining active status on the Wisconsin Nurse Aide Registry. Example 1CNA CC was hired 8/7/13.CNA CC only had 9 of 12 required hours of education.CNA CC had no evaluation in her file.Example 2CNA DD was hired 5/28/14.CNA DD only had 9 of 12 required hours of education.CNA DD's last evaluation was dated 3/1/23.Example 3CNA EE was hired 4/6/21.CNA EE only had 10 of 12 required hours of education.CNA EE had no evaluations in her file.Example 4CNA FF was hired on 1/3/22.CNA FF had no evaluation in her file.Example 5CNA/MA AA (CNA/Med Aide) was hired on 10/6/21. CNA/MA AA only had 8.5 of 12 required hours of education.CNA/MA AA's last evaluation was dated 8/25/23. On 7/9/25 at 3:35 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if CNA CC, CNA EE, and CNA FF had any evaluations in their files, NHA A said no. Surveyor asked NHA A if CNA DD or CNA/MA AA had a current evaluation in their files, NHA A stated no.On 7/9/25 at 4:16 PM, Surveyor interviewed NHA A. Surveyor asked NHA A how often are CNA evaluations to be completed, NHA A said annually. Surveyor asked NHA A should each CNA have a current evaluation, NHA A stated yes. Surveyor asked NHA A how many education hours are CNAs required to have annually, NHA A replied 12 hours. Surveyor asked NHA A should each CNA have at least 12 hours annually, NHA A stated yes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 1 of 1 sampled residents (R7) for change of condition.R7's medical record is missing documentation of her change of condition and subsequent passing away on 6/19/25. R18 has no nursing documentation following suicidal ideations documented by Activities.R19 has no documentation regarding the resident-to-resident altercation with R18.Evidenced by:The Facility policy Charting and Documentation, indicates, in part: Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: .2. The following information is to be documented in the resident medical record: a. Objective observations .c. Treatments or services performed .d. Change in resident's condition .e. Events, incidents or accidents involving the resident . Example 1R7 was admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's disease; Seizures; and Unspecified intellectual disabilities-chronic intellectual disability.R7's last progress note on 6/9/25 at 2:33PM is a Quarterly RD (Registered Dietician) Assessment. After the this note, R7's medical record does not include her change of condition, the facility's actions or R7 expiring at the facility. On 6/30/25 at approximately 3:15PM Surveyor interviewed MA AA (Medication Aide) who indicated she was working with R7 on 6/19/25 when she had a significant change in condition. On 7/1/25 at 9:09AM Surveyor interviewed LPN BB (Licenses Practical Nurse) who indicated she was working with R7 on 6/19/29 when she had a significant change of condition. The following is a synopsis of the events of R7's change in condition based on these interviews: MA AA indicated that she went into R7's room to check on her. MA AA indicated when she saw R7, her arms were down at her sides and her head was kind of down, her eyes were open, she was breathing but not responding verbally when MA AA was saying her name. MA AA indicated she went into the hallway and called for the nurse who came right away. MA AA indicated R7 still wouldn't respond verbally but was breathing on her own. MA AA indicated she left to go get another nurse who called 911. LPN BB indicated when she walked into the room R7's bedside table was on the side of her with the meal tray. LPN BB indicate R7 was sitting straight up, all the way up and breathing normally. LPN BB evaluated R7 and indicated R7 was conscious, and she was trying to get her to respond, she called her name and was talking to her trying to get her to respond or say something. LPN BB indicated she had asked the CNA to get the crash cart, suction, oxygen, and more nurses. LPN BB indicated the CNA came back with the DON (Director of Nursing) when they were bringing everything in and that 911 had already been called. LPN BB indicated the DON took over and was getting vitals, assessing and indicated R7's lungs were clear. LPN BB indicated EMS arrived and took over care of R7. R7 did pass away at the facility.On 7/1/25 at 2:40PM Surveyor interviewed ADON D (Assistant Director of Nursing) and asked if R7's medical record should include documentation of all the events related to her change of condition and passing away on 6/19/25. ADON D indicated, yes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2The Facilities Suicide Threats Policy and Procedure dated December 2007, documents in part: .8. Staff shall document details of the situation objectively in the resident's medical record .R18's Progress Notes document the following:06/14/2025 02:38 PMResident was upset because they couldn't go to the parade on Sunday. They started making suicide comments. Saying, I just going to cut my throat, I don't want to live anymore, I'm just done with life, and I just want a sharp object. Staff was able to redirect her thoughts to a new topic on fixing cars and going to Walmart. But once the staff was saying they are going and saying bye. Resident mentioned that they are still upset about not going to the parade and wanted to hunt them self. Staff inform CNAs and Nurse about the residents' comments and told them to keep a close eye on her and keep her mind distracted.Based on the above documentation, there is no evidence in R18's record the facility followed up with R18 after she made these suicidal comments.On 7/2/25 at 4:01 PM, Surveyor interviewed ADON D (Assistant Director of Nursing). Surveyor asked ADON D would you expect there to be nursing documentation regarding suicidal ideations, ADON D stated yes.On 7/2/25 at 4:23 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if he would expect there to be nursing documentation surrounding a resident making suicidal ideations, NHA A stated yes.R18's medical record is not complete and does not depict the actions taken.Example 3The Facilities Policy and Procedure entitled Resident-to-Resident Altercations dated September 2022, documents in part: .i. complete a Report of Incident/Accident form and document incident, findings, and any corrective measures taken in the resident's medical/clinical record .:R18's Progress Notes document the following:06/19/2025 12:37 AMIntervention needed by staff between this resident (R18) and R19; R19 kept calling out loudly and repeatedly a staff's name who was not available. R18 (this resident) started yelling language (shuddup) to her and physically becoming more agitated. She was told to calm down, and leave her alone and finally R18 took her plate and abruptly left the MDR (main dining room) w (with) her supper. But down north hall to her room she continued using cursive (cursing) [NAME] (language) disrupting other peers; no further occurrence this shift. [sic]R19's medical record has no documentation regarding the resident-to-resident altercation from 6/19/25.On 7/2/25 at 4:23 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A should there be documentation of a resident-to-resident altercation, NHA A stated yes.R19's medical record is not complete and does not depict the actions taken.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility did not maintain a Quality Assessment and Assurance Committee consisting of at a minimum, the Director of Nursing Services, the Medical Director, or his/her designee, at least three other members of the facility's staff at least one of whom must be the administrator, owner, a board member or other individual in a leadership role, and the Infection Preventionist, which met at least quarterly. This has the potential to affect all 48 Residents residing within the facility. Quality Assurance and Performance Improvement (QAPI) meetings did not consist of the required attendees/members for the months of June 2024 and July 2025. Two of the meetings over the last 4 quarters did not occur within the appropriate timeframe.This is evidenced by:The facility policy, entitled Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership, revised March 2020, states, in part: .6. The following individuals serve on the committee: a. Administrator or a designee who is in a leadership role; b. Director of Nursing Services; c. Medical Director; d. Infection Preventionist; and e. Representatives of the following departments, as requested by the Administrator: 1. Pharmacy; 2. Social Services; 3. Activity Services; 4. Environmental Services; 5. Human Resources; and 6. Medical Records .7. The committee meets at least quarterly (or more often as necessary) . On 12/5/24 at 9:10 AM, Surveyor reviewed the facility's QAPI committee meeting sign in sheets for the last four quarters and noted the following:The QAPI sign in sheet dated 6/19/24 (Quarter 1), did not include the Medical Director (MD).The QAPI sign in sheet for Quarter 2 is dated 12/4/24. The June meeting was the last month of quarter 1 which would make the following meeting due in July, August, or September 2024.The QAPI sign in sheet dated 7/7/25 (Quarter 4), did not include the Medical Director. Surveyor observed the QAPI sign in sheet from the Quarter 3 meeting and discovered that meeting occurred on 3/6/25. The March meeting was the last month of the quarter which would make the following meeting due in April, May, or June 2025.On 7/9/25 at 3:35 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who verified the Medical Director (MD) was not present at the 6/19/24 and 7/7/25 QAPI meetings, stated the Medical Director is a required member, and indicated QAPI committee should meet at least quarterly. NHA A also indicated there were no other QAPI meetings for 2024 and 2025 thus far. NHA A verbally told Surveyor he called the MD the day following the 7/7/25 meeting and informed the MD of what was discussed at the meeting. NHA A showed Surveyor his phone displaying the call placed to MD. Surveyor was unable to find documentation of phone conversation on QAPI meeting sign in sheet.