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	08/13/2025

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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(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** Based on interview and record review, the facility did not immediately notify and consult with a resident's physician when there was a significant change in condition. This occurred for 1 of 10 residents (R9) reviewed for notification of change in condition.R9 had blood sugars above the ordered parameter of 350 without notification of a physician. This is evidenced by: The facility's policy titled Medication and Treatment Orders, revised in July 2016 states in part, Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretations and Implementation: .9. Orders for medications must include: a. name and strength of the drug; b. number of doses, start and stop date, and/or specific duration of therapy; c. dosage and frequency of administration; d. route of administration; e. clinical condition or symptoms for which medication is prescribed; and f. any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.). R9 was admitted to the facility on [DATE] and has diagnoses that include: type 2 diabetes mellitus (a disorder which affects the body's ability to produce enough insulin or to effectively use the insulin it produces which can raise blood sugar levels). R8's physician orders include: *Insulin Aspart U-100 solution; 100 unit/mL; Amount to Administer: Per Sliding Scale; If Blood Sugar is 151 to 200, give 1 Units.If Blood Sugar is 201 to 250, give 2 Units.If Blood Sugar is 251 to 300, give 3 Units.If Blood Sugar is 301 to 350, give 4 Units.If Blood Sugar is greater than 350, give 5 Units.If Blood Sugar is greater than 350, call MD (Medical Doctor).Subcutaneous, three times a day (8:00 AM, 12:00 PM, 4:00 PM).Order start date: 08/11/2025 R9's August 2025 Medication Administration Record (MAR) shows documentation of blood sugars above the parameter of 350 on the following days:*8/11/25 4:00 PM blood sugar 378*8/12/25 12:00 PM blood sugar 368 On 8/12/25 at 4:12 PM, Surveyor interviewed RN I (Registered Nurse) and asked about blood sugar protocols. RN I stated nurses take residents' blood sugar when indicated. RN I stated a progress note would be made in the resident's chart if the doctor was contacted regarding a blood sugar being too low or too high. Surveyor reviewed R9's progress notes. There were no progress notes indicating that R9's doctor had been contacted about the two blood sugars that were over 350. On 8/12/25 at 4:20 PM, Surveyor interviewed DON B (Director of Nursing) about R9's blood sugar levels. DON B stated she would expect the doctor to be notified both times R9's blood sugar was over 350. These notifications should be charted. DON B reviewed R9's progress notes and confirmed that nothing had been charted to indicate that the doctor had been contacted. DON B noted that the nurse practitioner had seen R9 in the afternoon on 8/12, noted that his blood sugar levels had been high, and added new orders, which DON B said she would enter into the computer system. On 8/13/25, Surveyor observed the following progress note in R9's chart written by LPN H (Licensed Practical Nurse): Late Entry: On 8/12/25 at 1:47 p.m. resident's BG [blood glucose] was taken and read 368. Parameters state to notify provider for any readings over 350. Writer called PCP [primary care provider] office to inform them of yesterdays [sic] elevated readings. No new orders for resident.

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 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 misappropriation of resident property are reported immediately to the administrator of the facility in accordance with State law for 1 of 1 allegation reviewed.LPN H (Licensed Practical Nurse) did not report a suspicion of misappropriation of medication.As evidenced by:The facility's Loss or Theft of Medications policy, dated 9/1/10, states, in part: .Procedure 1. Where the community staff suspect theft or loss of medications, community staff should take such actions as required by Applicable Law and community policy. Appropriate actions should include, but not limited to: 1.1 Immediately reporting suspected theft or loss of medications to a supervisor/manager, the Director of Clinical Services or designee for appropriate investigation and follow-up.The facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, dated 9/2022, states, in part: .Reporting Allegation to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to law.On 8/13/25 at 8:40 AM, LPN H asked to speak with Surveyor. LPN H stated that two Saturdays ago, RN/IP M (Registered Nurse/Infection Preventionist) asked for the keys to the medication cart. LPN H stated that RN/IP M took the keys from LPN H's pocket and LPN H left the cart and went to a resident room; upon LPN H's return to the medication cart, RN/IP M stated that RN/IP M had left RN/IP M's blood pressure medications at home and that RN/IP M had found what RN/IP M was looking for and then RN/IP M left. LPN H stated that LPN H felt that RN/IP M may have taken medication from the cart, so LPN H did a count of the narcotic medications and found the count to be correct. LPN H stated there was no way to tell if other medications had an accurate count. Surveyor asked if LPN H reported the concern to the NHA (Nursing Home Administrator). LPN H stated no. Surveyor asked if suspicion of misappropriation is reportable. LPN H stated yes, you should tell the DON (Director of Nursing) or NHA (Nursing Home Administrator). Surveyor asked if LPN H told the DON or NHA. LPN H stated no.On 8/13/25 at 12:55 PM, Surveyor interviewed NHA A and asked about suspicion of misappropriation of medication. NHA A stated that staff would be expected to immediately report the suspicion to the DON or NHA and then an investigation would be started. Surveyor asked if suspicion of misappropriation of medication had been reported by LPN H. NHA A stated no. Surveyor asked if NHA A would have expected LPN H to report it. 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide showering assistance for residents requiring assistance for 1 of 6 residents (R2) reviewed for showers.R2 did not receive weekly showers.This is evidenced by:The facility's policy titled Bath, Shower/Tub, dated 2/18, includes: The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s).R2 admitted to the facility on [DATE] with diagnoses that include primary osteoarthritis of bilateral shoulders (arthritis that occurs when flexible tissue at the ends of bones wears down).R2's comprehensive care plan, printed 8/13/25, indicates R2 has impaired ADL (Activities of Daily Living) performance related to osteoarthritis and requires one assistance with personal cares.On 8/13/25 at 8:52 AM, Surveyor interviewed DON B (Director of Nursing) regarding showers and the documentation of showers. DON B indicated CNAs (Certified Nursing Assistant) give the showers and document on a paper form. The CNAs give the form to the nurse and the nurse will put the completed form in the drop box for medical records. Medical records will upload the form into the resident's electronic medical record. Surveyor asked DON B about R2's showers. DON B reviewed R2's electronic medical record and was able to locate R2's shower sheets for May 3, 6, and 13. DON B was not able to find any documented showers after May 13. DON B indicated medical records may have sheets in her office that she had not uploaded yet. DON B indicated CNA F would have more information on showers. DON B indicated if it wasn't documented then it wasn't done.On 8/13/25 at 9:25 AM, Surveyor interviewed MR G (Medical Records) about R2's shower sheets. MR G indicated shower sheets are uploaded into the resident's electronic health record. MR G stated she would look for R2's shower sheets. MR G provided surveyor with R2's shower sheets dated 6/7/25, 6/28/25, and 7/15/25.On 8/13/25 at 1:00 PM, Surveyor interviewed CNA F regarding showers. CNA F indicated showers are given at a minimum of weekly but more often if a resident wants.R2's showers were scheduled twice a week on Tuesdays and Saturdays. R2 has documented showers for 5/3/25, 5/6/25, 5/13/25, 6/7/25, 6/28/25 and 7/15/25.Of note, R2 should have received a total of 23 showers between 5/3/25 and 7/19/25. The facility was only able to provide documentation of 6 showers.On 8/13/25 at 8:52 AM, Surveyor interviewed DON B about documentation. DON B indicated if it wasn't documented then it wasn't done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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 did not ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 1 residents (R5) reviewed for bowel management. R5 was sent to hospital emergency department for constipation. Facility did not monitor bowels and perform abdominal assessments per facility protocol. Evidenced by:The facility's Bowel Management Protocol, undated, states, in part: 1. NOC (night shift) nurse will run the Resident Bowel Management Report in Matrix each NOC shift . 2. Identify all residents who have not had a bowel movement in the last 2 or more days and add them to the Nurse's Daily Bowel Report.5. Follow this procedure for residents with 2 or more days since last bowel movement Day #2 (number) No Bowel Movement-. Day #3 No Bowel Movement . -PM Nurse (evening shift) will complete a full bowel assessment and document a progress note in Matrix. -NOC Nurse will complete a full bowel assessment and administer bisacodyl (stimulant laxative used for constipation) 10 mg (milligrams) suppository per Standing Orders on last rounds with CNAs (Certified Nursing Assistants) then document a progress note in Matrix. Day #4 No Bowel Movement .AM Nurse will complete a full bowel assessment and document a progress note in Matrix.PM Nurse will complete a full bowel assessment.and document a progress note in Matrix. Day #5+ No Bowel Movement .AM Nurse will complete a full bowel assessment and document a progress note in Matrix.PM Nurse will complete a full bowel assessment.and document a progress note in Matrix.The facility's Care Path Gastrointestinal (GI) Symptoms, INTERACT, dated 6/2018, states, in part: New or Worsening GI Symptoms or Signs: *nausea and/or vomiting *diarrhea *constipation *abdominal pain *distended abdomen. Take Vital Signs. Evaluate Symptoms and Signs for Immediate Notification.Manage in Facility: monitor vital signs and abdominal exam findings every 4-8 hours. R5 admitted to the facility on [DATE] with diagnoses that include, in part: traumatic ischemia of muscle (a severe medical condition where a physical injury reduces blood flow to the muscles causing tissue damage); rhabdomyolysis (a severe muscle damage condition where muscle cells break down); weakness; unspecified dementia, moderate, with agitation (cognitive decline that significantly interferes with daily life); other abnormalities of gait and mobility.R5's Resident Bowel Management Report indicates:*7/18/25 and 7/19/25 blank*7/20/25 L (large)*7/21/25 -7/29/25 blankImportant to note: this is 9 days with no bowel movement documented in report*7/30/25 L*7/31/25-8/1/25 blank*8/2/25 M (medium)*8/3/25-8/12/25 blankImportant to note: this is 10 days with no bowel movement documented in report7/ R5's Progress Notes include:*7/21/25 11:08 PM Resident reported discomfort and stated she hadn't had a bowel movement (BM). PRN Miralax (laxative) given. Fluids encouraged.Important to note: no bowel assessment documented.*7/22/25 2:11 PM Resident states feels constipated. Miralax was given on NOC shift 7/21 and also at 12:00 PM. Prune Juice was given at 9:00 AM. This has had little effect. Small BMS have been produced, but nothing larger. At 2:30 PM AM nurse reported to PM nurse to give suppository.Important to note: no bowel assessment documented7/23/25 9:25 AM Resident stated that she is having abdominal pain d/t (due to) constipation. Resident has received prune juice, miralax, and stool softeners. Resident states that she has had small BMs but nothing quantity. Resident states that she would like to be sent to ER for evaluation.Important to note: no bowel assessment documentedR5's Emergency Department (ED) note states, in part: Encounter details Date 7/23/25 11:02 AM .History of Present Illness: .Patient has been constipated and has some nausea with this. Her last bowel movement was 3-4 days ago.She does report some bloating. Emergency Department Course and Interventions: .I did perform fecal disimpaction (a medical procedure to manually remove a large mass of dry, hard stool stuck in the rectum) and removed a moderate amount of stool. I subsequently administered an enema (a liquid inserted into the rectum to cleanse the bowel by stimulating bowel movements or clearing impacted stool) and R5 had a large bowel movement. R5 tolerated mag citrate (laxative) and additionally had an even larger bowel movement.I did encourage R5 to start using daily Miralax for additional treatment of constipation.On 8/12/25 at 11:10 AM, Surveyor interviewed FM O (Family Member) who stated that R5 had to be sent to the hospital due to constipation. FM O questioned, how did R5 get so constipated? Were they not reviewing R5's BMs?.On 8/12/25 at 1:10 PM, Surveyor interviewed CNA Q (Certified Nursing Assistant) and asked about documentation of bowel movements. CNA Q stated they are not documented as CNA Q does not have access to the computer charting system. Surveyor asked if CNA Q reports BM information to anyone. CNA Q stated no.On 8/12/25 at 1:29 PM, Surveyor interviewed LPN H (Licensed Practical Nurse) and asked about documentation of bowel movements. LPN H stated there is a lot

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (R5) reviewed for falls.R5 was evaluated to be transferred with 2 assist and [NAME]-Steady (transfer device) and was transferred with 2 assist (with no device). Evidenced by:The facility's Safe Lifting and Movement of Residents policy, dated 7/2017, states, in part: 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. 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan.R5 admitted to the facility on [DATE] with diagnoses that include, in part: traumatic ischemia of muscle (a severe medical condition where a physical injury reduces blood flow to the muscles causing tissue damage); rhabdomyolysis (a severe muscle damage condition where muscle cells break down); weakness; unspecified dementia, moderate, with agitation (cognitive decline that significantly interferes with daily life); other abnormalities of gait and mobilityR5's Hospital Discharge summary, dated [DATE], includes a PT (Physical Therapy) progress note, dated 7/16/25, which states, in part: . Recommended transfer for nursing: 2 assist, with gait belt, with non-mechanical lift ([NAME] steady).R5's Progress Notes include:*7/17/25 6:47 PM .uses walker and w/c (wheelchair) and is 2 assist with transfers. *7/18/25 11:39 AM Care Plan recommendations: Transfers: 2 assist [NAME]-steady with gait belt.*7/18/25 1:44 PM .Uses walker and w/c and is 2 assist with transfers.*7/19/25 8:49 PM Late Entry 7/19/25 AM shift . uses walker and w/c and is 2 assist with transfers.*7/19/25 8:50 PM .uses walker and w/c and is 2 assist with transfers.*7/20/25 1:25 PM .uses walker and w/c and is 2 assist with transfers.*7/21/25 11:33 AM Care plan update: transfers 2 A (assist) pivot with gait belt. On 8/12/25 at 11:10 AM, Surveyor interviewed FM O (Family Member) who stated the facility wasn't ready for R5's admission; they didn't know how to transfer R5. FM O stated that, when R5 arrived at the facility, the transport was waiting to get R5 out of the chair and facility staff came in to transfer R5 without a device; they just tried to get R5 up. FM O stated, This is just shy of being negligent.On 8/12/25 at 1:29 PM, Surveyor interviewed LPN H (Licensed Practical Nurse) and asked how staff know a resident's transfer status upon admission. LPN H stated there is supposed to be new admission paperwork, but it is not always there. LPN H stated if the paperwork is not there, they will contact the DON (Director of Nursing) or therapy. Surveyor asked if a resident's transfer status is documented. LPN H states yes, in a Medicare/Progress note. Surveyor asked if a device has been used for transfer if the progress note says 'Is 2 assist with transfers'. LPN H stated no, if a device is used it would be stated in the note.On 8/12/25 at 2:01 PM, Surveyor interviewed TD P (Therapy Director) and asked how staff is aware of a resident's transfer status on admission. TD P stated the facility gets a discharge packet from the hospital that includes how the resident transfers with therapy and with staff. TD P stated that the facility staff uses this information until therapy at the facility has done an eval. Surveyor asked about R5's transfer status on admission. TD P reviewed the hospital discharge note and stated that TD P was an assist of 2 and 2-wheeled walker with therapy and an assist of 2 with gait belt and non-mechanical lift ([NAME] steady) with nursing. TD P stated that R5 was evaluated at the facility on 7/18/25 and [NAME] steady with 2 assist was recommended. TD P stated transfer status was changed to a 2 assist pivot transfer (no device) on 7/21/25. Surveyor asked if a 2 assist pivot transfer (no device) would be appropriate for nursing staff on admission. TD P stated it would not be recommended. On 8/12/25 at 2:56 PM, Surveyor interviewed DON B (Director of Nursing) and asked how staff are aware of a resident's transfer status at time of admission. DON B stated the hospitals call me with report and I write up a sheet to share the info with staff. Surveyor asked about R5's transfer status on admission. DON B stated the care plan was started and would include the transfer status. Surveyor asked DON B for the baseline care plan. DON B stated that DON B did not know where to locate it in the record. No baseline care plan provided. Surveyor asked about the hospital discharge recommendation of 2 assist and [NAME] steady for transfers. DON B stated that DON B entered the initial progress note with information that had been given to DON B from the hospital's phoned report. Surveyor asked DON B about the therapy evaluation on 7/18/25. DON B stated it indicates 2 assist [NAME]-steady with gait belt. Surveyor asked how R5 was transferred on 7/18/25 through 7/20/25. DON B stated they continued to transfer with 2

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F 0692 Level of Harm - Minimal harm or potential for actual harm 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 - 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 did not ensure residents with G-Tubes (gastrostomy feeding tube) were assisted with nutrition and hydration for 1 of 3 Residents (R2) reviewed for nutritional status.R2 did not receive his G-Tube feeding as ordered.This is evidenced by:The facility policy titled Enteral Tube feeding via Gravity Bag, dated11/18, includes: The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally. 1. Verify that there is a physician's order for this procedure. 3. Check the following information: a. Resident name, ID and room number. b. Type of formula. f. Method (pump, gravity, syringe). 5. Check the order to verify the type, amount, method and rate of administration. 9. When correct tube placement has been verified, flush tubing with at least 30 ml warm water (or prescribed amount). 5. Unless otherwise ordered, follow the feeing with 30 -60 ml of warm water. 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. Verification of tube placement. 3. Amount and type of enteral feeding and amount of flush. 4. The name and title of the individual(s) who performed the procedure. 5. All assessment data obtained during the procedure. 6. How the resident tolerated the procedure. 7. If the resident refused the procedure, the reason(s) why and the intervention taken. 8. The signature and title of the person recording the data.R2 admitted to the facility on [DATE] with a G-Tube (a feeding tube inserted into the stomach through the abdominal wall used to deliver nutrition, fluids, and medications when a person is unable to eat or drink).R2's comprehensive care plan, printed 8/13/25, includes: R2 requires a feeding tube to meet their nutrition and hydration needs and to support overall metabolic demands. Administer tube feeding as ordered by physician.Example 1R2's physician orders include the following:Diet: Jevity 1.2 cal via g-tube. Start date 11/26/24.Jevity 1.2 cal (lactose-reduced food with fibr) liquid; 0.06 gram-1.5 kcal/ml; amt: 1 carton; gastric tube Special instructions: Tube feed with bolus feedings 4 times a day. Dx for dysphagia and severe malnutrition.Flush with tap water 100 ml prior and to [sic] after tube feedings.Document amount given and amount flushed once a day; 9:00 PM. Start date 5/14/25. End date 7/14/25.Jevity 1.2 cal (lactose-reduced food with fibr) liquid; 0.06 gram-1.5 kcal/ml; amt: 1 carton; gastric tube Special instructions: Tube feed with bolus feedings 4 times a day. Dx for dysphagia and severe malnutrition. (or nutritional equivalent) Flush with tap water 100 ml prior and to [sic] after tube feedings.Document amount given and amount flushed once a day; 9:00 PM. Start date 7/14/25. End date 7/18/25.Of note, (or nutritional equivalent) was added to the order.Jevity 1.2 cal (lactose-reduced food with fibr) liquid; 0.06 gram-1.5 kcal/ml; amt: 1 carton; gastric tube Special instructions: Tube feed with bolus feedings 4 times a day. Dx for dysphagia and severe malnutrition.Flush with tap water 100 ml prior and to [sic] after tube feedings.Document amount given and amount flushed once a day; 9:00 PM. Start date 7/18/25.Of note, (or nutritional equivalent) was removed from the order.On 8/12/25 at 11:09 AM, Surveyor interviewed FM J (Family Member). FM J indicated she had emailed NHA A (Nursing Home Administrator) on 7/16/25 regarding the use of Fibersource HN instead of R2's physician ordered Jevity 1.2. FM J included a picture of the Fibersource HN next to the container of Jevity 1.2 that was in R2's room. FM J indicated she was concerned about the facility changing R2's tube feeding formula without a physician's order.On 8/12/25 at 3:07 PM, Surveyor interviewed NHA A (Nursing Home Administrator) about ordering tube feeding formulas. NHA A indicated he does not do the ordering but knows the facility has never run out of Jevity 1.2 as other residents receive that same formula.On 8/12/25 at 11:40 AM, Surveyor interviewed LPN H (Licensed Practical Nurse) regarding R2's tube feeding formula. LPN H indicated DON B (Director of Nursing) said the staff can use Fibersource HN as an equivalent to and in place of Jevity 1.2 for R2's tube feeding. LPN H indicated R2 did not want to use Fibersource HN and wanted to continue to use Jevity 1.2. LPN H indicated she notified DON B on 7/17/25 that R2 only wanted to use Fibersource HN. LPN H indicated the facility did not run out of Jevity 1.2 but wanted to use the surplus of Fibersource HN that was in their supply.On 8/13/25 at 8:52 AM, Surveyor interviewed DON B regarding R2's tube feeding formula. DON B indicated Fibersource HN was nutritionally equivalent to Jevity 1.2 and since there was a surplus of Fibersource HN in the facility, DON B added the verbiage or nutritional equivalent to R2's tube feeding order on 7/14/25. DON B indicated LPN H informed her on 7/17/25, that R2 did not want to use Fibersource HN. DON B indicated on 7/18/25 she removed the verbiage from R2 tube feeding order. DON B stated a change in formula for a tube feeding should have a physician's order. DON B indicated she did not obtain a physician's order to use an equivalent but should have.Example 2R2's July 2025 MAR

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were seen by a physician every 30 days for the first 90 days after admission and every 60 days thereafter for 1 of 15 resident (R4) reviewed. R4 was not seen by a physician once every 30 days for the first 90 days after admission.Evidenced by:The facility policy, entitled Physician Services, dated 2/21, states, in part: . Policy Statement: The medical care of each resident is supervised by a licensed physician.Policy Interpretation and Implementation: .7. Physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. According to OBRA '87, OBRA regulations mandate specific frequencies for physician visits in nursing homes. A resident's attending physician must conduct an initial comprehensive visit within 30 days of admission. Following this, visits must occur at least every 30 days for the first 90 days, and then at least every 60 days thereafter.Example 1R4 admitted to the facility on [DATE] with diagnoses that include cellulitis of left lower limb (a common and potentially serious bacterial skin infection), venous insufficiency (chronic) (peripheral) (a condition where veins, primarily in the legs, have difficulty returning blood to the heart, leading to blood pooling and increased pressure in the veins), and edema (swelling that occurs when fluid builds up in the body's tissues). R4's admission Minimum Data Set (MDS) Assessment, dated 6/30/25 shows R4 has a Brief Interview of Mental Status (BIMS) score of 9, indicating R4 has moderate cognitive impairment. R4's Transitional Visit from Hospital to SNF (skilled nursing facility) note, dated 6/24/25, indicates reason for visit is nursing home visit and shows R4 was seen by a nurse practitioner (NP) on this date. There is no evidence in R4's medical record that R4 was seen by a physician initially after admission to facility and 30 days after. On 8/13/25, at 12:51 PM, Surveyor interviewed DON B (Director of Nursing) and asked if the nursing home visit note dated 6/24/25 was the only NP/MD (Nurse Practitioner/Medical Doctor) visit for R4 since admission on [DATE]. DON B indicated yes. Surveyor asked DON B when should a new admit be seen by a physician. DON B indicated within 30 days, then 60 days and then again 90 days after. Surveyor asked if R4 was seen by a physician as she indicated, and DON B indicated no.

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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 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. (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 0755 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 did not provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 7 residents (R5 and R10) reviewed for medications.R5 had medications not administered as orderedR10 had medications not administered as ordered This is evidenced by:The facility's policy titled Providing Pharmacy Products and Services, revised on 6/1/2018, states in part: .1. The Pharmacy will provide the community with a community-specific information sheet that details how community staff can contact the Pharmacy twenty-four (24) hours a day, seven (7) days a week.The facility's policy titled Medication Errors, revised on 9/1/10, states in part: .Omission error: Community fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of a recognized contraindication.The facility's policy titled General Dose Preparation and Medication Administration, revised on 6/30/23, states in part: .7. After medication administration, the community should: 7.1 Document necessary medication administration /assistance/observation/treatment information.on appropriate forms or electronic medication record.Example 1R5 was admitted to the facility on [DATE] with diagnoses that include: delusional disorders; unspecified psychosis not due to a substance or known physiological condition (psychotic symptoms with an unknown cause; generalized anxiety disorder; and unspecified dementia, moderate, with agitation.R5's July 2025 and August 2025 MAR (Medication Administration Record) documents the following medications were not administered after being admitted to the facility:*Olanzapine tablet; 15 mg (milligrams); Amount to Administer: 1 tab; oral-Frequency: At bedtime-Diagnosis: Unspecified psychosis not due to a substance or known physiological condition-Start date: 7/17/25~07/17/2025 8:00 PM: Not Administered: Drug/Item Unavailable *Olanzapine tablet; 5 mg; Amount to Administer: 1 tab; oral-Diagnosis: Unspecified psychosis not due to a substance or known physiological condition-Start date: 7/17/25~07/17/2025 8:00 PM: Not Administered: Other Comment: medication not available *Lorazepam - Schedule IV tablet; 0.5 mg; Amount to Administer: 1 tab; oral-Frequency: Once a day-Start Date: 7/17/25~07/18/2025 8:00 AM: Not Administered: Drug/Item Unavailable / Comment: pharmacy contacted On 8/13/25 at 1:10 PM, Surveyor interviewed DON B about the facility's medication process again. DON B indicated in a perfect world, it is never acceptable to miss medications. Surveyor asked about R5's missed medications - specifically the olanzapine. DON B confirmed that this medication is in the facility's contingency supply and R5 should have gotten it. DON B indicated that agency staff does not have access to the contingency medication. A code or fingerprint is needed to access these medications. Her expectation is that staff who does not have access should follow up with someone who does. DON B stated she would consider this a medication error. Example 2R10 was admitted to the facility on [DATE] with diagnoses that include: chronic idiopathic constipation; anxiety disorder; depression; undifferentiated somatoform disorder (mental health condition with physical symptoms that cause distress and functional impairment but have no known medical cause); chronic pain; gastro-esophageal reflux disease without esophagitis (stomach acid or other contents flow back into the esophagus without damaging the esophageal lining); and irritable bowel syndrome.R10's August 2025 MAR documents the following medications were not administered after being admitted to the facility: *Asmanex HFA (mometasone) HFA (hydrofluoroalkane - chemical used in inhalers) aerosol inhaler; 100 mcg (micrograms)/actuation; Amount to Administer: 1 puff; inhalation-Instructions: Inhale 1 puff 2 times daily for asthma~08/12/2025 4:00 PM: Not Administered: Drug/Item Unavailable~08/13/2025 8:00 AM: Not Administered: Drug/Item Unavailable / Comment: pharmacy contacted *Cromolyn concentrate; 100 mg/5 mL (milliliters); Amount to Administer: 5 ml; oral-Frequency: Four times a day~08/12/2025 4:00 PM Not Administered: Drug/Item Unavailable~08/12/2025 8:00 PM Not Administered: Drug/Item Unavailable~08/13/2025 8:00 AM Not Administered: Drug/Item Unavailable / Comment: pharmacy contacted~08/13/2025 12:00 PM Not Administered: Drug/Item Unavailable / Comment: pharmacy contacted *Cromolyn [OTC (over-the-counter)] spray, non-aerosol; 5.2 mg/spray (4%); Amount to Administer: 1 to 2 sprays; nasal-Frequency: Twice a day~08/12/2025 4:00 PM Not Administered: Drug/Item Unavailable~08/13/2025 8:00 AM Not Administered: Drug/Item Unavailable / Comment: pharmacy contacted *Fluticasone propionate [OTC] spray, suspension; 50 mcg/actuation; Amount to Administer: 2 sprays; nasal-Frequency: Twice a day~08/12/2025 4:00 PM Not Administered: Drug/Item Unavailable *Hydrocortisone acetate suppository; 25 mg; Amount to Administer:

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Ingleside Manor	407 N Eighth St Mount Horeb, WI 53572

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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 0760 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 did not ensure residents are free of any significant medication errors for 1 of 7 residents (R8) reviewed for medications.The facility did not ensure R8 was provided all doses of her buprenorphine-naloxone (combination medication used to treat opioid addiction) and her cephazolin (antibiotic). This is evidenced by: The facility's policy titled Providing Pharmacy Products and Services, revised on 6/1/2018, states in part: .1. The Pharmacy will provide the community with a community-specific information sheet that details how community staff can contact the Pharmacy twenty-four (24) hours a day, seven (7) days a week.The facility's policy titled Medication Errors, revised on 9/1/10, states in part: . Omission error: Community fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of a recognized contraindication.The facility's policy titled Medication and Treatment Orders, revised in July 2016, states in part: .11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. R8 was admitted to the facility on [DATE] with diagnoses that include: infection and inflammatory reaction due to unspecified internal joint prosthesis, subsequent encounter (prosthetic joint infection); bipolar disorder; anxiety disorder; opioid dependence, in remission; major depressive disorder, single episode, moderate. R8's July 2025 MAR (Medication Administration Record) documents the following medications were not administered after being admitted to the facility:**Buprenorphine-naloxone - Schedule III tablet, sublingual; 8-2 mg; Amount to Administer: 1 Strip; sublingual-Four times per day-Dissolve 1 (one) strip under the tongue 4 times daily Reasons: Opioid Dependence-Start Date: 07/25/2507/25/2025 4:00 PM Not Administered: Drug/Item Unavailable07/25/2025 8:00 PM Not Administered: Drug/Item Unavailable07/26/2025 8:00 AM Not Administered: Drug/Item Unavailable Comment: contacted pharmacy07/26/2025 12:00 PM Not Administered: Drug/Item Unavailable Comment: contacted pharmacy07/26/2025 4:00 PM Not Administered: Drug/Item Unavailable Comment: provider and pharmacy contacted **Cefazolin in 0.9% sodium chloride solution; 2 gram(g)/100 mL(milliliter); Amount to Administer: 2 g; intravenous-Every 8 hours-2 (two) g by Intravenous route every 8 hours-Start Date: 07/25/2507/25/2025 10:00 PM Not Administered: Drug/Item Unavailable07/30/2025 6:00 AM Not Administered: Other Comment: RN (Registered Nurse) did not administer R8's progress notes document the following information related to her cefazolin:-07/30 @ 6:18 AM: Residents [sic] IV antibiotic Cefazolin not available. Pharmacy was contacted. Pharmacy staff stated they would be sending it out STAT [immediately] so she can receive her dose this morning. Plan of care will continue. NP [Nurse Practitioner] notified, message left with call back number.-07/30 @ 5:46 PM: Resident received IV antibiotic via STAT order. This order will get resident through two days of treatment. Writer contacted pharmacy and was told that full reorder will be coming from pharmacy tomorrow. On 8/12/25 at 4:12 PM, Surveyor interviewed RN I (Registered Nurse) about the medication process when a resident gets admitted to the facility. RN I indicated the DON (Director of Nursing) or admissions nurse checks admission orders and enters them into the computer when a resident enters the facility. If a medication is missing, a stock or contingency medication can be given. Otherwise, staff must wait the pharmacy to deliver the medications. They get delivered every night. The discharge medication orders from the hospital should be given to the facility for them to fax over to the pharmacy. Occasionally, nurses must call the pharmacy to order a missing medication. On 8/12/25 at 4:17 PM, Surveyor interviewed LPN L (Licensed Practical Nurse) and asked about the medication process when a resident gets admitted to the facility. LPN L indicated she does not know who puts the orders in, but the admissions nurse should do this, then the pharmacy delivers the medications after verifying them. Surveyor asked LPN L what she does if a medication is missing for a resident. LPN L indicated this happens a lot. She said she puts not given if they don't have it. If it's not in stock, I can't give it. On 8/12/25 at 4:20 PM, Surveyor interviewed DON B (Director of Nursing) about the medication process when a resident gets admitted to the facility. DON B indicated administration put the information into Matrix (their computer system) and the facility's pharmacy (located in Milwaukee) will make a delivery that night. Regular medications are on a cycle fill. If a medication is missing, staff should notify the DON or call the pharmacy and order the medications themselves. The contingency stock has some medications that can be used, but not all of them. On 8/13/25 at 9:20 AM, Surveyor interviewed LPN H. LPN H stated newly admitted residents are missing medications half the time. Surveyor asked what the process is when medications are missing

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Ingleside Manor	407 N Eighth St Mount Horeb, WI 53572

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 Residents (R4 & R15) of 2 opportunities for hand hygiene. Staff did not perform proper hand hygiene per standards of practice during wound care on R4. CNA K had a breach in infection control when performing pericare (cleansing of the genital area). Evidenced by: The facility policy entitled “Handwashing/Hand Hygiene,” undated, states, in part: … “Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: -Administrative Practices to Promote Hand Hygiene: 2. All personal are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors… -Indications for Hand Hygiene: 1. Hand Hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task… d. after touching a resident e. after touching the resident’s environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal… 5. The use of gloves does not replace hand washing/hand hygiene…” Example 1 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4 admitted to the facility on [DATE] and has diagnoses that include cellulitis of left lower limb (a common and potentially serious bacterial skin infection), venous insufficiency (chronic) (peripheral) (a condition where veins, primarily in the legs, have difficulty returning blood to the heart, leading to blood pooling and increased pressure in the veins), and edema (swelling that occurs when fluid builds up in the body’s tissues). R4’s Physicians Orders, dated 7/22/25, states, in part: … “-Ammonium lactate cream; 12%; Amount to Administer: topical. Frequency: Once a day. Special Instructions: Apply once daily for venous stasis. Start Date: 6/23/25-open ended… -Hydrochlorous acid (Vashe cleaning) solution; Amount to Administer: topical. Frequency: Once a day. Special Instructions: Apply one time daily. Purpose: Venous Stasis. Start Date: 6/23/25-open ended… -BLE (bilateral lower extremities): Cleanse with Vashe cleanser. Pat dry. Apply ammonium lactate lotion and double layer of tubi grips. If any open areas cover with foam border dressing once a day. Start Date: 7/22/25-open ended…” On 8/13/25, at 10:15 AM, Surveyor observed LPN C (licensed practical nurse) perform wound care on R4’s BLEs per Physicians Orders. LPN C removed gloves 5 times during wound care and applied new gloves without performing hand hygiene. On 8/13/25, at 10:40AM, Surveyor asked LPN C if hand hygiene should be performed after glove removal and before applying new gloves. LPN C indicated yes. Surveyor asked LPN C if she had performed hand hygiene after glove removal and before applying new gloves and LPN C indicated no. On 8/13/25, at 10:50AM, Surveyor interviewed DON B (Director of Nursing) and asked if hand hygiene should be performed in between removing gloves and applying new gloves and DON B indicated yes. Surveyor informed DON B of observation of LPN C changing gloves during wound care without hand hygiene. DON B indicated she would expect staff to perform hand hygiene in between glove changes. Example 2 The facility's Perineal Care policy, dated 2/2018, states, in part: Purpose The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation .b. wash perineal area .2 . Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth . On 8/13/25 at 9:38 AM, Surveyor observed CNA N (Certified Nursing Assistant) performing pericare for R15. CNA N had set up a wash basin at bedside that contained water and two wash clothes. CNA N took one washcloth and performed frontal pericare for R15. CNA N placed the used washcloth into the basin and took the second washcloth to rinse the soap from the resident. CNA N placed the second washcloth into the basin, grabbed a hand towel and dried the resident. CNA N placed the used hand towel onto the over the bed table next to R15’s water glass and cell phone. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 9:45 AM, Surveyor interviewed CNA N and asked if washcloths and hand towels are contaminated after being used for pericare. CNA N stated yes. Surveyor asked if the washcloths used for R15’s pericare had been placed in the wash basin after beginning pericare. CNA N stated yes. Surveyor asked if the hand towel had been placed on the bedside table next to R15’s water glass and cell phone. CNA N stated yes. CNA N stated that CNA N should have had additional clean washcloths for completion of peri care and that the used washcloths and towels should not go back into the wash basin or onto the over the bed table. Surveyor interviewed RN/IP M (Registered Nurse/Infection Preventionist) and asked about infection control with pericare. RN/IP M stated that the wash cloth and towel are contaminated after performing frontal pericare and should not be placed into the basin or onto the bedside table.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure effective pest control in the facility dining area, hallways and resident rooms for 8 of 10 sampled residents (R4, R6, R11, R12, R13, R14, R15 and R16). Residents voiced concerns with flies in the facility. Surveyor made observation of 6 flies on R4's left lower leg while interviewing R4. Evidenced by: The facility policy, entitled Pest Control, dated 2023, states, in part: . Policy Statement: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 2. Pest control services are provided by Professional Pest Control monthly and as needed. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services. Example 1 R4 admitted to the facility on [DATE] and has diagnoses that include cellulitis of left lower limb (a common and potentially serious bacterial skin infection), venous insufficiency (chronic) (peripheral) (a condition where veins, primarily in the legs, have difficulty returning blood to the heart, leading to blood pooling and increased pressure in the veins), and edema (swelling that occurs when fluid builds up in the body's tissues). R4's admission Minimum Data Set (MDS) Assessment, dated 6/30/25 shows R4 has a Brief Interview of Mental Status (BIMS) score of 9, indicating R4 has moderate cognitive impairment. On 8/12/25, at 3:00PM, Surveyor was interviewing R4 in the lounge area and observed 6 flies on R4's left lower leg and left foot. R4 swatted at the flies that swarmed by his head while talking with Surveyor. Example 2 R11 admitted to the facility on [DATE]. R11's Annual MDS Assessment, dated 6/16/25 shows that R11 has a BIMS score of 15 indicating R11 is cognitively intact. On 8/13/25, at 9:05AM, R11 indicated to Surveyor flies have been bad in the facility since the beginning of summer. R11 indicated a friend brought him in a fly swatter to use. Example 3 R13 admitted to the facility on [DATE]. R13's Quarterly MDS Assessment, dated 6/5/25 shows that R13 has a BIMS score of 14 indicating R13 is cognitively intact. On 8/13/25, at 9:08AM, R13 indicated to Surveyor that there are a lot of flies in his room. R13 indicated he complained to staff but could not recall to whom and he has not noticed the facility has done anything about the fly problem. Example 4 R12 admitted to the facility on [DATE]. R12's admission MDS Assessment, dated 6/26/25 shows R12 has a BIMS score of 14 indicating R12 is cognitively intact. On 8/13/25, at 9:12AM, Surveyor asked if R12 had concerns and R12 indicated there are a lot of flies that are flying around in his room. Example 5 R14 admitted to the facility on [DATE]. On 8/13/25, at 9:15AM, R14 indicated to Surveyor there are a lot of flies in his room and in the facility. R14 indicated he voiced concern to CNAs (Certified Nursing Assistants), but he has not noticed any changes or if the facility has done anything regarding the flies. Example 6 R6 admitted to the facility on [DATE]. R6's admission MDS Assessment, dated 5/19/25 shows that R6 has a BIMS score of 12 indicating R6 has moderate cognitive impairment. On 8/13/25, at 9:17 AM, R6 indicated to Surveyor that there is a lot of flies in his room and throughout facility. R6 indicated the flies are huge. R6 states They are trying to haul me out of here! R6 indicated the flies even bite and at mealtimes the flies land on the food and he must swat them away. R6 indicated there are several residents that have talked about how bad the flies are, and the staff are aware.Example 7On 8/13/25, at 09:34 AM, Surveyor observed a fly sticky strip hanging down from the bulletin board in R15's room. Example 8On 8/13/25, at 09:35AM, Surveyor observed ant strips on the floor by the window covered with ants in R16's room. Surveyor observed a fly swatter on a dresser in the room. On 8/13/25, at 09:25AM, Surveyor interviewed MW E (maintenance worker) who indicated he is aware of the fly issues and had heard from a couple residents who have voiced concerns regarding fly issues. MW E indicated the facility is in contact with the PEST control people and he believes they did come to facility, but MW E would have to check as the previous maintenance director has left facility. MW E indicated the facility has put up some sticky strips for the flies in a few rooms. Surveyor asked MW E if there was a plan in place now for the fly issues and MW E indicated he cannot answer that as he is not the maintenance director, but he will look into it and get back to Surveyor.On 8/13/25, at 10:50AM, Surveyor informed DON B (Director of Nursing) that Surveyor has a concern with PEST control regarding the fly concerns voiced from residents and with Surveyors observations of flies. DON B indicated PEST control are coming this week. On 8/13/25, at 11:40AM, MW E indicated he had phoned the PEST control people and found out part of the facility's contract with the PEST control is they spray exteriorly twice a year. MW E indicated it is now changed to three times a year. MW E indicated he has a meeting set up for Monday with a guy from Terminix to go over options regarding the fly issue.