| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525331 | A. Building<br>B. Wing | 07/11/2024 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552<br><br>Based on observation, interview and record review the facility failed to ensure 2 (R19 and R25) of 16 sampled residents and 2 (R17 and R23) of 4 supplemental residents had a call light within reach or a means to call staff for assistance.<br><br>Surveyor observed R19's and R23's call lights not within reach.<br><br>R25 and R17 voiced concern that their call lights are not always within reach, making it difficult to call for staff assistance.<br><br>Evidenced by:<br><br>The facility policy titled, Call System, Residents, dated 9/23, states, in part; .Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station .1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .<br><br>Example 1<br><br>R23 was admitted to the facility on [DATE] with a diagnoses including respiratory failure, unspecified dementia, anxiety disorder, chronic pain, cognitive communication deficit, and pressure induced deep tissue injury.<br><br>R23's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 6/22/24, indicates R23 has a BIMS (Brief Interview for Mental Status) score of 13 indicating R23 is cognitively intact.<br><br>On 7/8/24 at 10:33 AM, Surveyor observed R23's call light on the side bar of R23's bed. R23 was sitting in Broda chair, unable to reach call light as it was behind resident attached to the bed. R23 indicated R23 was unable to reach call light.<br><br>Example 2<br><br>R25 was admitted to the facility on [DATE] with a diagnoses including hypertension, peripheral vascular disease, diabetes, stroke, and manic depression.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R25's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/28/24, indicates R25 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R25 is cognitively intact.<br><br>On 7/10/24 at 11:04 AM, R25 indicated there are times he is unable to reach the call light. R25 indicated there was one time he had to call the main number multiple times to reach a staff member because it was later in the evening. R25 indicated there are times R25 has to yell out to get staff attention because R25's call light is not within reach.<br><br>Example 3<br><br>R17 was admitted to the facility on [DATE] with a diagnoses including fracture, muscle weakness, age related osteoporosis, stiffness, other reduced mobility, and heart disease.<br><br>R17's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/24/24, indicates R17 has a BIMS (Brief Interview for Mental Status) score of 8 indicating R17 is moderately cognitively impaired.<br><br>On 7/10/24 at 11:04 AM, R17 indicated there are times that the call light is not within reach when R17 is in her room. R17 indicated she has to yell until someone hears her because she can not move independently on her own.<br><br>50285<br><br>Example 4<br><br>R19 was admitted to the facility on [DATE] with diagnoses that included heart failure, morbid obesity, acute respiratory failure, unsteadiness on feet, muscle weakness, fatigue, and history of falls.<br><br>R19's Quarterly Minimum Data Set (MDS) dated [DATE] documented R19 had a Brief Interview for Mental Status (BIMS) score of 15 which indicates she is cognitively intact and able to make her needs known.<br><br>On 7/8/24 at 11:00 AM, Surveyor observed R19 siting in her room in her wheelchair with a blue tourniquet tied above her elbow on her right arm. R19 indicated that she gets weekly blood draws done at the facility. Surveyor observed that R19's call light was behind her, tied to the bed rail, and out of R19's reach.<br><br>On 7/8/24 at 11:03 AM, Surveyor found one of the Certified Nursing Assistants (CNA) in the hallway and asked her to send a nurse to R19's room.<br><br>On 7/8/24 at 11:19 AM, Surveyor reached behind R19 and pushed her call light button with her permission.<br><br>On 7/8/24 at 11:20 AM, R19's call light was answered by Licensed Practical Nurse K (LPN), who removed the tourniquet.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/11/24 at 10:17 AM NHA A (Nursing Home Administrator) indicated he would expect call lights to be within reach of resident when resident is in their room or in the bathroom.<br><br>The facility failed to ensure all residents had a call light within reach or a means to call staff for assistance. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849<br><br>Based on interview and record review, the facility did not immediately consult with the resident's physician when there was a need to alter treatment for 2 of 7 residents (R49 and R18) reviewed for physician notification out of a total sample of 16 Residents.<br><br>R49's provider was not notified of a positive urine culture and sensitivy result therefore delaying a treatment decision by the provider.<br><br>R18 missed medications and R18's physician was not notifed.<br><br>This is evidenced by:<br><br>The facility's policy Lab and Diagnostic Test Results - Clinical Protocol with a review date of 11/27/23, indicates, in part: .Identifying Situations that Warrant Immediate Notification - 1. Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic tests results: .Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and it is not stable or improving, or there are no previous results for comparison .Options for Physician Notification -- .b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification .Physician Responses - 1. Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and clinical significance of the information. a. A physician should respond within one hour regarding a lab test requiring immediate notification, and by the end of the next office day to a non-emergency message non-immediate lab test notification with a request for response (for example, by late Wednesday afternoon for a call made on Tuesday). b. If the Attending or Covering Physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance .<br><br>Example 1<br><br>R49 has a current admitted to the facility of 3/13/24, with diagnoses that include in part: Malignant neoplasm of colon, Retention of Urine, Neuromuscular dysfunction of bladder, and Type 2 Diabetes Mellitus.<br><br>On 7/9/24 Surveyors reviewed R49 for UTI (Urinary Tract Infection) as part of the overall Infection Control Task. At 3:30PM Surveyors requested documentation of the final C & S (Culture and Sensitivity) report from ADON/IP C (Assistant Director of Nursing/Infection Preventionist). At 3:45PM the report was provided to surveyor.<br><br>The report included the following information:<br><br>Fax Received date at top of report: 7/4/24 9:36AM<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Collected: 7/1/24 - 12:29PM Received 7/1/24 - 12:29PM<br><br>Run Date: 7/4/24 Run Time: 9:35AM<br><br>Result: Urine Culture Final<br><br>Organism 1 - Klebsiella pneumoniae >100,000 CFU/ml (colony forming unit/ml) at day 2<br><br>Organism 2 - Pseudomonas aeruginosa >100,000 CFU/ml at day 2 .<br><br>At the bottom right hand side of the report is handwritten, in part, Faxed resident sent to ED per on call . (remaining illegible).<br><br>Of note, surveyors were unable to find documentation that R49 went to the emergency room or hospital.<br><br>On 7/9/24 at 4:45 PM, DON B (Director of Nursing) approached surveyor and informed surveyor that she spoke with NP R (Nurse Practitioner) who indicated she did not receive the fax and it would have went to the on-call if it did go anywhere, but she cannot locate it. DON B indicated R49 did not go out to the hospital and she is not sure why the report says that at the bottom. NP R informed DON B that she asked for the result yesterday and no one could locate it. DON B indicated that R49 had not been treated for the positive urine culture but that his urine remains clear and he is asymptomatic at this time. Surveyor asked DON B if someone should have followed up with the provider when they did not get a response to the fax that was sent. DON B indicated, yes, at least by the next day.<br><br>On 7/10/24 at 10:56 AM, Surveyor interviewed NP R and asked if it is acceptable for staff to send a fax with positive results instead of calling. NP R indicated they usually do a bit of both. I check my fax pretty frequently, usually they will follow-up with me the next day if they don't hear back from me on a fax. Because this one came back on a holiday they should have called the on-call on 7/4 when this was received and then tried again on 7/5 to call me or on-call because there was no response. Surveyor asked NP R when she was made aware of R49's culture results. NP R indicated 7/9 when DON B asked her about it. Surveyor asked NP R if she had been informed of the results sooner would she have treated R49. NP R indicated she would have treated and then informed urology for further guidance.<br><br>44552<br><br>Example 2:<br><br>R18 was admitted to the facility on [DATE] with a diagnoses including heart failure, vascular disease, diabetes, and respiratory failure.<br><br>R18's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 5/29/24, indicates R18 has a BIMS (Brief Interview of Mental Status) score of 15 indicating R18 is cognitively intact.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 7:25 AM, RN Q (Registered Nurse) indicated she was the RN that discovered R18's nighttime medications were not signed out on 6/16/24. RN Q does not remember if she notified DON B (Director of Nursing). RN Q indicated she did not notify primary physician of the missed medications.<br><br>On 7/11/24 at 2:42 PM, DON B indicated she was not aware that R18 missed nighttime medications on 6/16/24. Surveyor asked DON B if primary physician should have been notified of missed medications. DON B stated, Absolutely, primary physician should have been notified of the missed medications. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552<br><br>Based on observation, interview and record review the facility failed to provide a comfortable and homelike environment for 1 of 16 total sampled residents (R38) and 3 of 4 supplemental residents (R13, R27, and R17) reviewed.<br><br>R38 voiced concern that the water in R38's bathroom is always cold. R38 indicated that R38 is not able to take a shower so his main form of washing up and showering is done at his bathroom sink.<br><br>R13, R27, and R17 indicated that they have had cold showers and that the water in the shower room does not warm up.<br><br>Evidenced by:<br><br>The facility policy titled, Water Temperatures, Safety of, dated 12/2009, states, in part; .2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log .<br><br>Example 1<br><br>R38 was admitted to the facility on [DATE] with a diagnoses including personal history of traumatic brain injury, adjustment disorder with mixed anxiety and depression, weakness, and difficulty in walking.<br><br>R38's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 4/21/24, indicates R38 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R38 is cognitively intact.<br><br>On 7/8/24 at 10:38AM, R38 indicated he does not have hot water in his bathroom sink. R38 indicated he does not use the shower room and he only uses his bathroom sink to wash up and have a sponge bath. R38 indicated his bathroom water has never been hot and he has reported this. Surveyor took the temperature in R38's bathroom sink. Surveyor noted the temperature of the bathroom water to be 85.2 F (degrees Fahrenheit) .<br><br>Example 2<br><br>R17 was admitted to the facility on [DATE] with a diagnoses including fracture, muscle weakness, age related osteoporosis, stiffness, other reduced mobility, and heart disease.<br><br>R17's most recent MDS with ARD of 4/24/24, indicates R17 has a BIMS score of 08 indicating R17 is moderately cognitively impaired.<br><br>On 7/11/24 at 11:04 AM, R17 indicated she recently had a cold shower. R17 indicated she told the CNA that was assisting her with the shower that the water was too cold. R17 indicated the shower was uncomfortable because it was cold.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/9/24 at 9:04 AM, CNA P (Certified Nursing Assistant) indicated she assisted a resident with a shower today. CNA P indicated the water temperature was appropriate for that shower. Surveyor and CNA P took the temperature of the water in the shower and it was 89 F. CNA P indicated she let the water run for quite some time before assisting person with shower. CNA P indicated the water does not feel hot right now.<br><br>On 7/9/24 at 9:43 AM, M I (Maintenance) indicated he thought someone was coming out to look at the water temperatures on Friday, but he's not sure if they came yet. M I indicated he would provide temperature logs, work orders, and any invoices as soon as possible.<br><br>On 7/9/24 at 9:54 AM, CNA J indicated the water temperature has been an on and off issue. CNA J indicated you have to let it run for a very long time. CNA J indicated she has heard residents voice concerns with the temperature of their showers. CNA J indicated staff report concerns to maintenance and they will fix it, but it is an ongoing issue.<br><br>On 7/10/24 at 8:50 AM, MD G (Maintenance Director) indicated he has not heard any concerns with the water temperature on the west hallway. MD G indicated he would expect staff to report if there were concerns. MD G indicated he had heard that the east hallway shower room was cold so he adjusted the valve and that corrected the issue.<br><br>On 7/10/24 at 2:30 PM, NHA A (Nursing Home Administrator) indicated he would expect staff to report the water temperature concerns if it continued being an issue. NHA A indicated he remembers a report a few months ago regarding water temperature concerns and maintenance adjusting the valve and the issue was corrected.<br><br>The facility failed to ensure water temperature was appropriate and at a comfortable temperature for all residents.<br><br>50285<br><br>Example 3<br><br>R13 was admitted to the facility on [DATE] with diagnoses that include morbid obesity, chronic pain syndrome, muscle weakness, fibromyalgia, dizziness, weakness, and history of falls.<br><br>R13's Quarterly Minimum Data Set (MDS) dated [DATE] documented R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates she is cognitively intact and able to make her needs known. R13's MDS functional abilities indicate that R13 is completely dependent on staff for showering/bathing assistance.<br><br>R13's care plan, dated 5/3/24, with a target date of 8/13/24, states: impaired Activities of Daily Living (ADL) performance related to weakness and lack of motivation. Interventions include 1-2 assist with dressing and showering.<br><br>On 7/8/24 at 9:40 AM, Surveyor interviewed R13 who indicated that she receives showers twice a week with staff assistance. R13 indicated that yesterday they had cold water for the shower. R13 states that staff will let the water run, but that it doesn't get warm. R13 stated that she feels unpleasant when she has to take cold showers.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Example 4<br><br>R27 was admitted to the facility on [DATE] with diagnoses that include Parkinson's syndrome, unspecified dementia, dizziness, weakness, chronic fatigue, decreased mobility, and history of falls.<br><br>R27's Quarterly Minimum Data Set (MDS) dated [DATE] documented R27 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicates he is moderately cognitively impaired. R27's MDS functional abilities indicate that R27 requires substantial/maximum staff assistance for showering/bathing.<br><br>R27's care plan, dated 4/1/19, with a target date of 8/31/24, states: impaired Activities of Daily Living (ADL) and physical mobility related to weakness and memory loss. Interventions include one assist with dressing and showering.<br><br>On 7/8/24 at 12:02 PM, Surveyor interviewed R27 who indicated that he receives weekly showers with staff assistance. R27 indicated that yesterday he had taken a cold shower. R27 states that the water temperature varies, it is not always consistent.<br><br>On 7/10/24 at 8:09 AM, Surveyor interviewed Certified Nursing Assistant (CNA) P, who indicated that she was aware that the shower temperature was cold ad times, but that she will turn it on and let it run for awhile to warm it up.<br><br>On 7/10/24 at 8:18 AM, Surveyor interviewed CNA H, who indicated that the facility did have an issue with the water temperature, but that she turns the water on and lets it run while she gets and prepares the resident for their shower. CNA H stated that she had not made maintenance or anyone in management aware of the shower temperature issue.<br><br>On 7/10/24 at 9:09 AM, Surveyor interviewed Maintenance Director G who indicated he had not been made aware of an issue with water temperature in the hallway shower. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038<br><br>Based on interview and record review the facility did not develop a comprehensive, person-centered care plan for 1 of 16 sampled Residents (R14) reviewed for person centered care plans.<br><br>The facility failed to develop and implement a care plan that addressed monitoring for side effects such as bruising or bleeding for R14, who is taking Eliquis (Apixaban).<br><br>Evidenced by:<br><br>The facility's policy titled Care Plans, Comprehensive Person-Centered with a revision date of March 2022, states in part .3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .7. The comprehensive, person-centered care plan: a. includes measurable objectives and time frames .e. reflects currently recognized standards of practice for problem areas and conditions .<br><br>According to the Mayo Clinic, .Apixaban is used to treat or prevent deep venous thrombosis, a condition in which harmful blood clots form in the blood vessels of the legs. These blood clots can travel to the lungs and can become lodged in the blood vessels of the lungs, causing a condition called pulmonary embolism. This medicine is used for several days after hip or knee replacement surgery while you are unable to walk. It is during this time that blood clots are most likely to form .Apixaban is also used to prevent stroke and blood clots in patients with certain heart rhythm problem (e.g., nonvalvular atrial fibrillation) .Apixaban is a factor Xa (Xa is activated form of the coagulation factor X) inhibitor, an anticoagulant. It works by decreasing the clotting ability of the blood and helps preventing harmful clots from forming in the blood vessels .You may bleed and bruise more easily while you are using this medicine. Be extra careful to avoid injuries. Stay away from rough sports or other situations where you could be bruised, cut, or injured. Gently brush and floss your teeth. Be careful when using sharp objects, including razors and fingernail clippers. Avoid picking your nose. If you need to blow your nose, blow it gently. Check with your doctor right away if you have any unusual bleeding or bruising, black, tarry stools, blood in the urine or stools, headache, dizziness, or weakness, pain, swelling, or discomfort in a joint, pinpoint red spots on your skin, unusual nosebleeds, or unusual vaginal bleeding that is heavier than normal. These may be signs of bleeding problems . Apixaban (Oral Route) Description and Brand Names - Mayo Clinic.<br><br>R14 was admitted to the facility on [DATE] with diagnoses that include Type 2 diabetes mellitus, congestive heart failure, paroxysmal atrial fibrillation, and a history of falling. R14's most recent MDS (Minimum Data Set) dated 6/24/24 states that R14 has a BIMS (Brief Interview of Mental Status) of 5 out of 15, indicating that R14 has severe cognitive impairment. R14's MDS also indicates that he is dependent on staff for toileting, bathing, and transfers.<br><br>R14's physician orders state the following: .Start Date: 6/21/24 .Eliquis (apixaban) tablet; 5mg (milligrams) . Special Instructions: Take 1 tab PO (orally) 2x (twice) daily dx (diagnosis) atrial fibrillation .<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | It is important to note that R14 has had 14 falls since being admitted to the facility on [DATE]. Additionally, R14's care plan does not indicate that R14 is taking an anticoagulant (blood thinner), nor does it indicate that staff should be monitoring for any side effects related to being on Eliquis.<br><br>On 7/11/24 at 10:42 AM, Surveyor interviewed RN E (Registered Nurse). Surveyor asked RN E what staff monitors for when a resident is on an anticoagulant, RN E stated that they monitor for bruising, bleeding, vital signs, and shortness of breath. Surveyor asked RN E how often they monitor for side effects, RN E stated that they do daily vital signs and weekly skin checks. Surveyor asked RN E if there was anything on R14's MAR/TAR (Medication Administration Record/ Treatment Administration Record) for monitoring, RN E stated no. Surveyor asked RN E if there was anything in R14's care plan related to Eliquis, RN E stated no.<br><br>On 7/11/24 at 3:07 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the expectation is for the care plan of a resident that is taking Eliquis, DON B stated that staff should be monitoring for bleeding and making sure the resident is taking their medications. Surveyor asked DON B how often staff should be monitoring for bruising and bleeding, DON B stated staff should be monitoring every shift. Surveyor asked DON B if R14 should have a care plan for Eliquis, DON B stated yes. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038<br><br>Based on interview and record review, the facility did not ensure that a resident received treatment and care to prevent hospitalization in accordance with professional standards of practice for 1 of 6 residents (R18) that were reviewed for hospitalization s out of a total sample of 16.<br><br>R18 had a change in condition and the facility did not complete full assessments and monitor symptoms. R18's condition continued to decline and R18 was hospitalized with atrial flutter (an abnormal heart rhythm in the heart's upper chambers (atria) when the atria beats too fast. This may cause dizziness and fatigue,) acute decompensated heart failure with preserved ejection fraction (Decompensated heart failure is a phase in the progression of chronic heart failure where symptoms worsen and become more severe. The heart cannot pump enough blood to meet the body's needs under this condition. Patients may experience acute shortness of breath, significant swelling in the legs or abdomen due to fluid accumulation, and fatigue, among other symptoms,) and pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart.)<br><br>Evidenced by:<br><br>AMDA (American Medical Directors Association) guidelines, 2003, state, in part: In the long term care setting, a primary goal of identifying ACOCs (Acute Change of Conditions) is to enable staff to evaluate and manage a patient at the facility and avoid transfer to the hospital or emergency room .Examples of Staff Roles and Responsibilities in Monitoring Patients With ACOCs .Staff nurse *Recognize condition change early, *Assess the patient's symptoms and physical function and document detailed descriptions of observations and symptoms, *Update the charge nurse or supervisor if patient's condition deteriorates or patient fails to improve within expected time frame, *Report patient status to practitioner as appropriate .<br><br>The facility's policy titled Acute Condition Changes - Clinical protocol dated 3/18/24, states in part, .2. In addition, the nurse shall assess and document/ report the following baseline information: a. Vital signs; b. Neurological status; c. Current level of pain .d. Level of consciousness; e. Cognitive and emotional status; .j. All active diagnoses .8. The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less) .Treatment/ Management: 1. The physician will help identify and authorize appropriate treatments .3. If it is decided, after sufficient review, that care or observation cannot reasonably be provided in the facility, the physician will authorize transfer to an acute hospital, emergency room , or another appropriate setting .<br><br>R18 was initially admitted to the facility on [DATE] with diagnoses to include acute and chronic respiratory failure, type 2 diabetes mellitus, lymphedema (swelling caused by excess lymph fluid within the body,) chronic kidney disease stage 3, chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs,) and congestive heart failure (impairment in the heart's ability to fill and pump blood.)<br><br>R18's most recent MDS (Minimum Data Set) dated 5/29/24 states that R18 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R18 is cognitively intact.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R18's care plan dated 1/22/21 states in part, .Category: ADLs (Activities of Daily Living) Functional Status/Rehabilitation Potential: Impaired physical mobility R/T (related to) my size and de-conditioning d/t (due to) recent illness .Approach start date: 10/7/2023 Transfers: one assist SPT (Stand-Pivot Transfer)<br><br>R18 was readmitted from the hospital on 10/6/23 with diagnoses that include decompensated heart failure.<br><br>R18's weights are as follows:<br><br>10/6/23: 345<br><br>10/7/23: 357.8<br><br>10/8/23: 352<br><br>(Of note: R18 is up 12 pounds on 10/7 and indicated as being up 7 pounds on 10/8/23, there is no documentation the provider was updated or that an assessment was completed for R18 regarding her weight gain with a history of CHF.)<br><br>Nurse's notes state the following:<br><br>On 10/8/23 at 9:38 PM: Resident used hoyer lift (full body lift) to transfer from wheelchair to bed due to fatigue. Noted increased fatigue in afternoons/evenings. Had 2 short episodes of retching this shift. Appears tired with facial expressions. Vital signs within baseline. Continues to oxygen at 2 L/M (liters per minute) via nasal cannula .<br><br>It is important to note that there are no documented vital signs or assessments to accompany R18's change of condition. R18 was transferred via a Hoyer lift due to fatigue when she was a stand pivot upon returning from the hospital per her care plan on 10/7/23. There is no documentation of R18's provider being notified.<br><br>On 10/8/23 at 11:59 PM Vital signs are documented as follows: O2 saturation 96% on 3 liters, blood pressure 142/94, respirations 28/per minute, pulse 126/per minute.<br><br>On 10/9/23 at 12:33 AM: wretching [sic] frequently productive small amount of sputum, tums received. VS (Vital Signs) recorded Pulse 128, R (Respirations) 28-32, O2 (oxygen) 3 L/min NC (Nasal Cannula). 2400 (12:00 AM) requested to sit at side of bed. When CNAs (Certified Nursing Assistant) arrived she was sitting at bedside .Continued to wretch [sic], without emesis, tired appearance. Explained condition as it relates to VS.<br><br>On 10/9/23 at 12:38 AM: Cardiopulmonary assessment: Breath sounds clear R (right), crackles L (left) base post (posterior). Note, feet black when dependent. She asked for her daughter, states she is coming Tuesday.<br><br>It is important to note that the facility did not contact the physician when R18 had an elevated heart rate, increased respirations, increased oxygen need, or when R18's feet were noted to be black when dependent. There were no further vital signs or assessments documented.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/9/23 at 2:54 PM: Per report from noc (night) nurse: resident was tachycardic in the 130s, RR (respiratory rate) near 40, O2 sat (saturation) stable. On-call MD (Medical Doctor) notified and resident sent to (hospital name) ER (emergency room ), leaving around 0430 (4:30 AM).<br><br>R18 was in the hospital from 10/9/23- 10/18/23.<br><br>The hospital's Inpatient Discharge Summary dated 10/18/23 states in part, .Primary Discharge Diagnosis: Atrial Flutter, AKI (Acute Kidney Injury) II on CKD (Chronic Kidney Disease) III, Acute decompensated heart failure with preserved ejection fraction (HFpEF), and Pulmonary hypertension .Details of Hospital Stay: . recent hospitalization (10/2-10/6 for decompensated HF (Heart Failure) admitted with acute on chronic HFrEF (heart failure with a reduced ejection fraction). And atrial flutter. Hospital Course: Control of atrial flutter attempted with adjustment of beta blockade (medications used to treat irregular heartbeat, high blood pressure, and are given after a heart attack). Cardiology was consulted for cardioversion (medical treatment that uses quick, low-energy shocks to restore a regular heart rhythm) which she underwent on 10/11 with successful conversion to sinus rhythm .Regarding [R18] decompensated heart failure she was aggressively diuresed with IV (Intravenous) bumetanide (a diuretic used to reduce extra fluid in the body (edema) caused by conditions such as heart failure, liver disease, and kidney disease.) .With regards to her respiratory failure she was treated similar to COPD (Chronic Obstructive Pulmonary Disease) exacerbation given fairly significant wheezing on exam even after aggressive diuresis. She was given a prednisone burst (steroid) with improvement in respiratory symptoms .<br><br>The facility's admission note dated 10/18/23 states in part, .New pulmonary edema noted during this hospital stay. UA (Urinalysis) positive, treated with antibiotics. [R18] was given IV metoprolol 2.5 mg (milligrams) x2 ., Bumex 4mg IV, K (potassium) and Mg (Magnesium) repletion, a 1L bolus of LR (Lactated Ringers (fluids)), Duonebs (nebulizer), and started on cefepime (antibiotic) while still in the ED (Emergency Department).<br><br>On 7/11/24 at 9:37 AM, Surveyor interviewed NP R (Nurse Practitioner). Surveyor asked NP R when the on-call MD was notified of R18's condition. NP R stated that the facility called around 4:00 AM. Surveyor asked NP R if she would expect the facility to call with R18's change of condition. NP R stated that if R18 was having crackles in her lung sounds, they should have called, especially with her CHF and COPD. Surveyor asked NP R if she was updated on R18's 12 lb. (pound) weight gain, NP R stated no. NP R reported that the facility does not obtain a weight on the day of admission, but instead uses the hospital weight.<br><br>On 7/11/24 at 10:34 AM, Surveyor interviewed RN E (Registered Nurse). Surveyor asked RN E if R18's provider was notified of R18's 12 lb. weight gain from 10/6/23 to 10/7/23. RN E stated that the facility obtained a reweight on 10/8/23. Surveyor asked if the facility notified the provider of R18's weight on 10/8/23 which was a 7 lb. weight gain since admission, RN E stated no.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 7/11/24 at 3:23 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the facility's process is for weighing new admissions. DON B stated that the facility should be weighing them when they arrive. Surveyor asked DON B if staff should have notified the provider with R18's weight gain, DON B stated yes. Surveyor asked DON B if she would have expected the nurse to recheck R18's vital signs with the change in condition. DON B stated that she would expect the nurse to complete an assessment. Surveyor asked DON B if she would expect the nurse to notify the MD with R18's change of condition, DON B stated yes. Surveyor asked DON B if she would expect the nurse to complete the documentation on R18 and not leave it for the next shift, DON B stated yes.<br><br>It is important to note that the facility provided education to staff regarding change in condition and physician notification on 3/18/24, 4/29/24, and 6/24/24 but the nurse caring for R18 on the night of 10/18/23 did not attend or sign in on any of the education provided.<br><br>The facility failed to identify an acute change in condition and update the MD appropriately, resulting in R18 being hospitalized due to CHF and required IV diuretics. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434<br><br>Based on observation, interview, and record review, the facility did not ensure a resident receives care, consistent with professional standards of practice to prevent pressure injury (PI) development for 1 of 2 residents reviewed for PIs out of a total sample of 16 residents (R49).<br><br>R49 was assessed to be at risk for pressure injury on 4/28/24. The facility did not implement a repositioning plan.<br><br>Evidenced by:<br><br>The facility policy, entitled Pressure Ulcers/Skin Breakdown, dated April 2018, states, in part: Assessment and Recognition 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s) . Cause Identification 1. The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state, and macerated or friable skin . Treatment/Management . 2. The physician will help identify medical interventions related to wound management . a. Although poor nutritional status is associated with increased risk of pressure ulcer development, no specific nutritional interventions clearly prevent or heal ulcers . Monitoring . b. Current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision maker.<br><br>R49 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of colon, type 2 diabetes, moderate protein-calorie malnutrition, polyneuropathy, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left-sided weakness and paralysis following a stroke), dysphagia following cerebral infarction (difficulty swallowing following a stroke), depression, nutritional deficiency, neuromuscular dysfunction of bladder, and anemia.<br><br>R49's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/19/24, shows R49 has a BIMS score of 15 indicating R49 is cognitively intact. GG0130. Self-care. C. Toileting Hygiene. Dependent (Helper does all the effort. Resident does none of the effort to complete the activity). E. Shower/bathe self. Dependent. F. Upper body dressing. Dependent. G. Lower body dressing. Dependent. H. Putting on and taking off footwear. Dependent. I. Personal Hygiene. Dependent. GG0170 Mobility. A. Roll left and right. Dependent . E. Chair/Chair-to-bed transfer. Dependent. M0150. Risk of Pressure Ulcers. Is the resident at risk for Pressure Ulcers? Yes. M0210. Unhealed Pressure Ulcers. Does the resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? No.<br><br>R49's Care Plan states, in part: .<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Category: Pressure Ulcer/Injury. Start Date: 3/13/24. R49 is at risk for skin breakdown related to malnutrition, hemiplegia and diabetes type 2. Approach Start Date: 6/15/24: Supplements as ordered. Approach Start Date: 6/15/24: Weekly skin check on shower day. Approach Start Date: 4/4/24: Encourage R49 to be up in wheelchair/lift chair throughout the day. Approach Start Date: 3/13/24: Heels ARE identified as risk areas. APPLY: Elevate on Pillows, pressure offloading. Approach Start Date: 3/13/24: REPOSITIONING SCHEDULE: reposition for comfort and offloading.<br><br>Of note: No other documentation exists of a repositioning schedule within R49's medical record.<br><br>Category: ADLs Functional Status/Rehabilitation Potential. Start Date: 3/13/24 . Approach Start Date: 4/2/24: TRANSFERS: 2 A (2 assist) Hoyer Lift.<br><br>Braden Scale for Predicting Pressure Sore Risk completed on 4/28/24, indicates that R49 scored a 15 indicating that he is at risk for developing pressure wounds.<br><br>Progress Note on 6/6/24 at 3:49 PM states, OT (Occupational Therapist) reports new wound observed to L calf. Upon observation writer notes circular dark purple area to posterior calf with scabbed over area in the center. Non-blanchable. Purple discolored area measures 2.3 cm x 1.9 cm. scabbed over area measures 0.5 cm x 0.7 cm. No drainage.<br><br>On 7/11/24 at 9:28 AM, Surveyor interviewed R49. Surveyor observed resident lying in bed with heels up in place. Surveyor asked R49 if he needs help repositioning himself. R49 states that he does need help repositioning and that he cannot do it himself. Surveyor asked R49 if staff come in regularly to reposition him and if he ever refuses staff help. R49 states that it doesn't really work like that. He uses the call light to get help with repositioning, staff never just come in to reposition him, so he never refuses because the only time they come in to reposition is when he calls for assistance.<br><br>On 7/11/24 at 11:03 AM, Surveyor interviewed R49. Surveyor observed R49 sitting in his recliner, with a pillow under his legs. R49's calves rested on the footrest around where his wound is located. R49 gave Surveyor permission to touch his recliner. Recliner leg rest lined with cloth, but has a hard, nonmalleable layer directly underneath the cloth. Surveyor asked R49 if he has always had a pillow under his legs when sitting in the recliner. R49 says no, that this has been more recent. Surveyor asked R49 if the pillow was put in place after he developed his leg wound. R49 states, yes and then commented this recliner is the running theory.<br><br>On 7/11/24 at 11:33 AM, Surveyor interviewed CNA (Certified Nursing Assistant) M. Surveyor asked CNA M if R49 is on a repositioning schedule. CNA M states that his usual schedule is that he gets up from bed at 10:45 and moves from his bed to his recliner. Surveyor clarified and asked if R49 has any sort of regular schedule for repositioning. CNA M said he does not. Surveyor asked CNA M if R49 is able to reposition himself. CNA M states he is able to move his recliner with his remote but otherwise calls when he needs assistance.<br><br>On 7/11/24 at 11:27 AM, Surveyor interviewed RN (Registered Nurse) N. Surveyor asked RN N if she could observe the wound. RN N agreed. Surveyor observed a reddened area around the size of a nickel that is non-blanchable. No open areas exist. Surveyor had RN N confirm that there was no longer an open area. RN N confirmed that the wound had closed.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 2:53 PM, Surveyor interviewed DON (Director of Nursing) B. DON B states that the facility determined that his urinary catheter tubing was determined to be the root cause due to the tubing sitting under R49's leg while he was sitting in the recliner. DON B also states that R49 doesn't move a lot and his dependent for moving. Surveyor asked DON B if R49 is on a repositioning scheduled. DON B states that he is and he needs to be repositioned every 2-3 hours. DON B states that R49 does not request to be repositioned.<br><br>R49 is dependent on staff for repositioning and does not have a specified positioning schedule (i.e., frequency) beyond reposition for comfort and offloading on his care plan. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434<br><br>Based on interview and record review, the facility did not ensure a resident maintains acceptable parameters of nutritional status and weight. This affected 1 of 3 Residents (R49) reviewed for nutrition and hydration out of a total sample of 16 residents.<br><br>The facility failed to monitor R49's meal intake after R49 was assessed at risk for malnutrition and experienced weight loss.<br><br>Evidenced by:<br><br>The facility policy, titled, Weight Assessment and Intervention Policy, revised 2/2024, states, in part: Policy: Resident weights are monitored for undesirable or intended weight loss or gain. Procedure: 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team. 2. Weights are recorded in the residents' vitals. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. 4. Unless notified of significant weight change, the Dietician will review the residents' weights monthly to follow individual weight trends over time. 5. The threshold for significant unplanned weight loss will be based on the following criteria: a. 1 month - 5% weight loss. b. 3 months-7.5% weight loss. c. 6 months-10% weight loss. 6. If the weight change is desirable, this is documented.<br><br>R49 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of colon, type 2 diabetes, moderate protein-calorie malnutrition, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (left-sided weakness and paralysis following a stroke), dysphagia following cerebral infarction (difficulty swallowing following a stroke), depression, nutritional deficiency, and anemia.<br><br>R49's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 6/19/24, shows R49 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R49 is cognitively intact.<br><br>R49's Physician Orders state, in part: Start Date: 3/13/24, Diet-Low Fiber Diet, Liquid- Thin, Start Date: 3/20/24 Boost breeze (calorie and protein supplement drink) TID (three times a day), Start Date: 5/28/24, Provide 120 mL (milliliters) fluids with medication administrations to increase fluid intake, four times a day, Start Date: 04/02/24 Weekly weights .<br><br>R49's Comprehensive Care Plan states, in part: .Category: Dehydration/Fluid Maintenance. R49 has constipation episodes R/T (related to) history of neurogenic bowel . Approach (6/16/24): Encourage increased fluid intake to prevent dehydration .Category: Nutritional Status. R49 is at increased nutritional risk due to bowel surgery 2/2 (secondary to) colon cancer and caloric malnutrition .Approach (6/15/24): Administer supplements as ordered . Approach (3/21/24): DIET: low fiber diet. Approach (3/21/24): Do not eat foods that are irritating to your bowel. Try to limit highly acidic foods: Coffee, beer, wine, Coca-Cola and ALL soft drinks/carbonated drinks, tomato products, cranberry products, oranges and orange juice. Refer to your education materials regarding diet. Approach (3/21/24) obtain wts (weights) as ordered. Approach (3/21/24): Record meal and snack intake.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R49's Initial Nutrition Assessment states, in part: . Resident admitted following colon surgery 2/2 colon cancer. Resident is on a low fiber diet- special diet instructions in care plan. Offer boost clear TID (three times a day). Resident started on mirtazapine by NP (nurse practitioner). Wt: (Weight) 249# (pounds) .Care plan: Resident at increased nutritional risk following colon surgery 2/2 colon cancer.<br><br>R49's weights state, in part: .<br><br>3/21/24 249 lbs.<br><br>4/8/24 228 lbs. (8.43% loss)<br><br>6/5/24 224 lbs.<br><br>6/12/24 222.4 lbs. (10.68 % loss)<br><br>6/19/24 228.4 lbs.<br><br>6/26/24 233 lbs.<br><br>7/3/24 232.6 lbs.<br><br>7/10/24 232 lbs.<br><br>R49's meal intake states, in part: .<br><br>6/17/24 Lunch: 26-50%<br><br>6/17/24 AM Snack: None<br><br>6/17/24 Breakfast: 1-25%<br><br>6/15/24 Lunch: 76-100%<br><br>6/12/24 Lunch: None<br><br>6/12/24 Breakfast: None<br><br>6/12/24 AM Snack: None<br><br>6/11/24 Lunch: None<br><br>6/11/24 Breakfast: None<br><br>6/11/24 AM Snack: None<br><br>6/03/24 Breakfast: 51-75%<br><br>(continued on next page) |

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| | 525331 | A. Building<br>B. Wing | 07/11/2024 |

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

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6/03/24 Lunch: 76-100%<br><br>5/02/24 Dinner: 26-50%<br><br>4/30/24 Dinner: 51-75%<br><br>4/30/24 Breakfast: 1-25%<br><br>4/28/24 Breakfast: 1-25%<br><br>4/28/24 Lunch: None<br><br>4/25/24 Dinner: 26-50%<br><br>4/21/24 Breakfast: 1-25%<br><br>4/21/24 Lunch: 1-25%<br><br>4/20/24 Lunch: 1-25%<br><br>4/20/24 Breakfast: None<br><br>4/11/24 Breakfast: None<br><br>Of note: from 4/20/24 to 7/11/24, out of 82 days and a possible 246 meals, 20 meals had intakes charted. This does not include the missing snack charting.<br><br>Registered Dietician note from 6/17/24 states, in part: .Remains on low fiber diet, limited documentation regarding intakes via meals and supplement consumption .<br><br>Registered Dietician note from 6/18/24 at 8:27 AM states, in part, .Wt (weight) down 26# (lbs.) x 3 months, is considered nutritionally significant, will notify provider of wt change. Wt has been gradually trending up back to baseline. Currently at 222.4#. Remains on low fiber diet, thin consistency. Limited documentation regarding intakes consumed. Extra sauces/gravies provided with each meal to aid in xerostomia (dry mouth). Receives boost breeze TID (three times a day) for added[sic] kcal/pro (kilocalories/protein), acceptance unknown. Please document % consumed via records .<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 11:14 AM, Surveyor interviewed DM (Dietary Manager) F. Surveyor asked DM F what the process is for placing new dietary orders. DM F states that the registered dietician will call, text or email her if she has questions or concerns. If the registered dietician has new recommendations for a resident, an email will be sent to the dietary manager and the DON (Director of Nursing). Surveyor asks if R49's extra gravy and condiments had been communicated to DM F. DM F states she is aware, it is on his meal card, and her staff was made aware. DM F also adds that R49 is a particular eater, and usually refuses the main meal, but has a meal he asks for instead. DM F is knowledgeable about the exact order and explained the meal to Surveyor at this time. Surveyor asks DM F if R49 usually eats in the dining room or in his room. DM F states that he always takes his tray in his room. Surveyor asked who in the facility has the responsibility for charting food intakes. DM F indicates that the CNA's have that responsibility, however she was able to show me hand-written waste reports that indicate R49 usually doesn't drink his supplemental Boost in the morning but does for lunch and dinner.<br><br>On 7/11/24 at 2:53 PM, Surveyor interviewed DON (Director of Nursing) B. Surveyor asked how the communication process works between herself and the dietician. DON B states that the registered dietician is in the building on Saturdays, but reviews notes daily. If nurses identify problems, they will forward their concerns to the registered dietician. The registered dietician will send recommendations to DM F and DM F shares those recommendations with DON B. DON B also states that nursing staff is responsible for putting the orders into the EMR (electronic medical record). Surveyor asked DON B if CNAs should be documenting resident intake. DON B states that CNAs should be documenting resident intake. Surveyor asked DON B if the facility has a standard of practice for the frequency of weighing residents. DON B states they weigh residents according to physician order.<br><br>R49's meal intakes were not documented and R49's weight loss was not reviewed until 6/18/24 after R49 had a 26 pound or 10.68% weight loss in 3 months. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552<br><br>Based on interview and record review the facility failed to ensure all residents receive scheduled medications on time per physician orders for 1 (R18) of 14 residents reviewed for medications.<br><br>R18 did not receive night time medications on 6/16/24.<br><br>Evidenced by:<br><br>The facility policy titled, Administering Medications, dated 4/19, states, in part; .Medications are administered in a safe and timely manner, and as prescribed. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .<br><br>The facility policy titled, Documentation of Medication Administration, states, in part; .The facility shall maintain a medication administration record to document all medications administered .1. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR) .<br><br>R18 was admitted to the facility on [DATE] with a diagnoses including heart failure, vascular disease, diabetes, and respiratory failure.<br><br>R18's most recent MDS with ARD of 5/29/24, indicates R18 has a BIMS score of 15 indicating R18 is cognitively intact.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R18's June 2024 MAR, states, in part; .Lantus Solostar U-100 Insulin pen; 100 unit/ml (3ml (milliliters)); amount to administer: 20 units; subcutaneous .frequency at bedtime .inject 20 units under skin once daily at bedtime for type 2 diabetes mellitus .start date 5/28/24 .6/16/24 8:00PM .charted date 6/17/24 3:33AM Reasons: Not administered .Dicloxacillin capsule 500mg (milligrams) twice a day .take 1000mg by mouth 2 times daily chronic cellulitis start date 5/28/24 .6/16/24 8:00PM charted Date 6/17/24 3:33AM .Reasons Not administered: documentation does not support vs were completed by pm shift .Eliquis tablet 5mg twice a day .take 1 tab PO 2xdaily (twice daily) for afib .start date 5/28/24 .6/16/24 8:00PM Charted Date 6/17/24 3:33AM .Reasons Not administered: documentation does not support vs were completed by pm shift .fluticasone propionate twice a day 2 sprays each nostril 2 times daily for nasal allergies .start date 5/28/24 .charted date 6/17/24 3:33AM .Reasons Not administered: documentation does not support vs were completed by pm shift .Lipitor 20mg 1 tablet oral at bedtime take 1 tablet by mouth one time daily for high cholesterol/lipids .start date 5/28/24 .6/16/24 8:00PM .charted date 6/17/24 3:33AM .Reasons Not administered: documentation does not support vs were completed by pm shift .metoprolol succinate tablet extended release 24 hr; 100mg; amount to administer 1 tab; oral twice a day take 1 tab PO 2xdaily for afib .start date 5/28/24 .6/16/24 8:00PM .charted date 6/17/24 3:33AM Reasons Not administered: documentation does not support vs were completed by pm shift .potassium chloride tablet extended release twice a day take 10mEq (Milliequivalent) PO 2xdaily dt (due to) hypokalemia .start date 6/4/24 .6/16/24 8:00PM .charted 6/17/24 3:40AM Reasons note administered: documentation does not support vs were completed by pm shift .singulair tablet 10mg at bedtime take 1 tablet by mouth one time daily at bedtime for allergic rhinitis .start date 5/28/24 .6/16/24 8:00PM .charted 6/17/24 3:37AM Reasons not administered: documentation does not support vs were completed by pm shift .Symbicort HFA aerosol inhaler twice a day inhale 2 puffs daily into lungs twice daily for COPD rinse mouth with water after to reduce risk of thrust .start date 5/28/24 .6/16/24 8:00PM .charted 6/17/24 3:37AM Reasons not administered: documentation does not support vs were completed by pm shift .<br><br>On 7/10/24 at 11:00 AM, R18 indicated she did not receive her night time medications one evening a few weeks ago. R18 couldn't remember the exact date.<br><br>On 7/11/24 at 7:25 AM, RN Q (Registered Nurse) indicated she was the RN that discovered R18's nighttime medications were not signed out on 6/16/24. RN Q does not remember if she notified DON B. RN Q indicated she documented directly on R18's MAR, documentation does not support vs were completed by pm shift . RN Q indicated she had to document a note because everything shows up in red on the MAR when documentation is not completed and you are not able to move forward until something is documented. RN Q indicated she did not call the RN to verify if the medications were given. RN Q indicated she does not remember if R18 reported to her that she didn't get her medications. RN Q indicated R18 will report if she doesn't get medications or has any concerns.<br><br>On 7/11/24 at 9:23 AM, DON B (Director of Nursing), indicated if a nurse finds that medications from a previous shift have not been signed out that nurse should make a note in the progress notes and call the responsible nurse to ensure that the medications were given. DON B indicated if the medication is not signed out that means the medication was not given. DON B indicated DON B was unaware that R18's medications for 6/16/24 HS (night time medications) were not signed out. DON B indicated this would be considered a medication error. DON B indicated she would look back to double check if she was notified and will follow up with Surveyor.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 10:17 AM, NHA A (Nursing Home Administrator) indicated that medications need to be signed out on the MAR to be considered given to the resident. NHA A expressed understanding regarding the concern with R18's night time medications on 6/16/24.<br><br>On 7/11/24 at 2:42 PM, DON B indicated she was not aware that R18's night time medications were not signed out on 6/16/24.<br><br>The facility failed to ensure residents receive all scheduled medications on time per physician orders. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434<br><br>Based on interview and record review, the facility did not ensure that drug regimes are free of unnecessary psychotropic medications, and that a resident taking a psychotropic medication has a care plan that includes targeted behaviors for 1 of 5 residents (R11) reviewed for unnecessary medications.<br><br>R11 was started on Bupropion (antidepressant) for Other symptoms and signs involving cognitive functions and awareness, Quetiapine (antipsychotic) for Bipolar disorder, and Sertraline (antidepressant) for Bipolar Disorder and the care plan contained no behavior monitoring to assess the effectiveness of these medications,<br><br>Evidenced by:<br><br>The facility policy, entitled Psychotropic Medication Use, dated 7/2022, states, in part: Policy Statement. Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy interpretation and Implementation. 1. A psychotropic medication is any medication that affects brain activity associated with mental processes. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. anti-psychotics; b. anti-depressants; c. anti-anxiety medications and; d. hypnotics . 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences.<br><br>R11 was admitted to the facility on [DATE] with diagnosis that includes in part, Bipolar disorder, in full remission, most recent episode mixed and Dependent personality disorder.<br><br>R11's Part A Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/24 states in part, R11 has a Brief Interview for Mental Status (BIMS) of 14, indicating that R11 is cognitively intact. D0150 Resident mood interview: A. little interest or pleasure doing things. No. B. Feeling down, depressed, or hopeless. Yes-2-6 days (several days). R11's PPS (Prospective payment system) 5-day Scheduled MDS with ARD 5/29/24 also indicates a BIMS of 14, E0100 indicates no delusions or hallucinations, as well as no physical, verbal, or other behaviors directed towards staff were observed during the monitoring period. E0800 also indicates that the resident did not refuse cares during the observation period.<br><br>R11's Physician Orders state in part, Bupropion HCl (hydrochloride) 300 mg tablet extended release 24 hr - 1 tab, oral, Once A Day, Take 1 tablet by mouth once daily Start date: 5/23/24. Quetiapine 300 mg tablet - 1 tab, oral, At bedtime, Take 1 (one) tablet by mouth at bedtime. Reasons: mood disorder. Start date 5/23/24. Sertraline 100 mg tablet - 100 mg, oral, Once A Day. Start date: 6/13/24.<br><br>R11's comprehensive care plan states in part .<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Start date 6/24/24: Mood State: R11 has a potential for an altered mood pattern r/t (related to) loss of health and independence, relationship with wife fluctuates, unsure what his future holds[sic] regarding living situation, mental health diagnosis. Approach: convey an attitude of acceptance towards R11. Encourage to verbalize feelings, concerns, fears, etc. Clarify misconceptions. Establish a trusting relationship with R11. Explore with resident inner strengths and resources. Maintain a calm environment and approach. Provide reassurance and support during acute periods. Reinforce focus on reality. SS (Social Services) visits as needed to monitor mood pattern, provide a supportive and reassuring approach, assist in problem solving as needed and encourage him to be involved as much as able, promote a sense of well being, use humor as appropriate, praise for his active involvement in his care, routine, goals and POC (plan of care).<br><br>Start date 6/24/24: Psychotropic Drug Use: R11 receives antipsychotic medication r/t dx (diagnosis) of dependent personality disorder and bipolar. Monitored behaviors: expresses feeling helpless towards reaching his goals and making decisions for his future. Approach: AIMS (Abnormal Involuntary Movement Scale) every quarter, Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal (involuntary and uncontrollable movement) symptoms. Attempt a gradual dose reduction (if not contraindicated), Behavior interventions: reassure, 1:1 and problem solve, praise when making appropriate and self directed decisions. Monitor behavior and response to medication. Monitor for EPS (extrapyramidal symptoms). Pharmacy consultant review.<br><br>Of note: while the care plan specifies adverse side effects to monitor for, it does not actually list behaviors that the resident exhibits that, when monitored, would indicate effectiveness of the medications.<br><br>R11' Treatment Administration Record (TAR) dated June-July 2024, states in part, Target Behavior: (Seroquel and Sertraline). At the end of each shift mark Frequency- how often mood swing behavior occurred & Intensity-how resident responded to redirection. Intensity Code: 0=Did Not Occur; 1=Easily Altered; 2=Difficult to Redirect. 3= Redirectable with distraction. Target Behavior: R11 receives antidepressant medication r/t dx of dependent personality disorder. Monitored behaviors: expresses feeling helpless towards reaching his goals and making decisions for his future. At the end of each shift mark Frequency-how often behavior occurred & Intensity-how resident responded to redirection. Intensity Code: 0=Did Not Occur; 1=Easily Altered; 2=Difficult to redirect.<br><br>Of note: while the facility is documenting on these treatments every shift, they do not specify what mood swing behavior is and no additional behaviors besides expressing feeling helpless towards reaching his goals and making decisions for his future are listed. Bipolar disorder is a complex condition, characterized by manic and depressive behaviors including; extreme happiness or excitement, rapid speech, agitation, restlessness, less need for sleep, paranoia, inappropriate sexual behavior, sadness and crying, feelings of hopelessness, loss of energy, loss of interest in hobbies, trouble concentrating, irritability, need for more sleep, changes in appetite, weight loss or gain, and suicidal ideation.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 11:19 AM, Surveyor interviewed CNA (Certified Nursing Assistant) L. Surveyor asked CNA L how she knows which behaviors to monitor for each resident. CNA L states they go off their report sheets. Surveyor allowed to observe CNA's report sheet and found no behaviors listed for residents. CNA L states that if they don't tell me in report, I don't know what behaviors should be monitored. Surveyor asked if there are Care Cards in resident rooms. CNA L confirmed that there were, and CNA L and Surveyor went to R11's room to view Care Card. Surveyor found no behaviors to monitor for on the Care Card and CNA L agreed. CNA L reports she has not received any training on individualized behavior monitoring for residents.<br><br>On 7/11/24 at 11:33 AM, Surveyor interviewed CNA M. Surveyor asked CNA M how she knows which behaviors to monitor. CNA M states that information is usually passed in report and included on the care plan. Surveyor asked where that information is kept. CNA M states that most care plans are in the binder in the closet. Surveyor asked CNA M if the binder in the closet is where she would go to look for which behaviors need monitoring. CNA M states yes, she would check the binder in the closet. CNA M also states that the nurses are good about telling her what behaviors to watch for with residents. Surveyor asked CNA M if she documents resident behaviors. CNA M states she documents the behaviors and reports the behaviors to the nurse. CNA M states she documents in the EMR (Electronic Medical Record) to monitor behaviors and interventions such as re-directing. Surveyor asked CNA M to pull up R11's chart and then a different resident's chart. Surveyor observed that both residents had the same behaviors listed. Surveyor asked CNA if they have the same behaviors listed, are they individualized for each resident. CNA M states no, I guess not.<br><br>On 7/11/24 at 11:46 AM, Surveyor interviewed RN (Registered Nurse) N. Surveyor asked RN N if residents are on medications such as antipsychotics or antidepressants how are behaviors monitored. RN N states that if a resident is on these types of medications they are charted under the targeted behaviors and we chart symptoms on every shift. RN N also states that these behaviors are documented in the TAR and that the CNA's will let nurses know if a resident has a behavior. Surveyor asked RN N to pull up R11's TAR. RN N states that R11's TAR indicates to chart for mood swings. RN N states that R11 is very pleasant so if he had any kind of anger or something different from baseline staff would chart exactly what happened. Surveyor asked RN N if the behaviors listed in R11's TAR should be more specific to R11. RN agrees that the TAR should be more specific to R11's behaviors and what a mood swing is for R11. Surveyor asked RN N how staff monitors if the Sertraline is effective. RN N states that the TAR is pretty much it, so staff can pull up the history and it shows the number of times this behavior has occurred.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/11/24 at 2:44 PM, Surveyor interviewed DON (Director of Nursing) B. Surveyor asked DON B what the process is for deciding what individualized behaviors will be monitored for residents on psychotropic medications. DON B states when the facility does the comprehensive assessment (MDS) is when we get to know the resident a little bit and then we can put in the behaviors that need to be monitored. DON B also states that the Interdisciplinary Team (IDT) meeting also occurs to decide on what goes into the care plan. Surveyor asked DON B if staff should be aware of each resident's individualized behaviors. DON B states that the behaviors that need monitoring are posted in the resident's room in a maroon binder and they also include interventions to deescalate behaviors. DON B also indicates that there should be an order put in for targeted behavior tracking. Surveyor asked DON B where these behaviors would be listed. DON B states that they are in orders and the orders are pulled into the TAR electronically. Surveyor asked DON B to review R11's behavior listed for Seroquel and Sertraline, DON B reviewed these behaviors. Surveyor asked DON B if she would consider mood swing behavior as individualized or generalized. DON B states that the mood swing behavior is an initial general order that was put in place upon R11's admission, and they did not have actual behaviors to record at that time. Surveyor asked DON B if these behaviors should have been updated during the months since admission. DON B states that that is the only behavior she can find for those medications and it is accurate to say that we don't have monitoring for individualized behaviors for these two medications. During Surveyors interview with DON B, DON B was able to identify the problem within the EMR (Electronic Medical Record) as to why listed behaviors were not being pulled onto the care plan.<br><br>The facility failed to ensure that each residents comprehensive care plan included personalized targeted behaviors to monitor the efficacy of each medication. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>36192<br><br>Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 25 opportunities that affected 1 out of 5 residents (R46) included in the medication pass task, which resulted in an error rate of 8%.<br><br>RN D (Registered Nurse) did not administer R46's medications according to Physician orders.<br><br>This is evidenced by:<br><br>Facility policy entitled 'Adverse Consequence and Medication Errors,' states in part: 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported.4. The staff and practitioner shall strive to minimize adverse consequences by: a. following relevant clinical guidelines and manufacturer's specification for use, dose, administration, duration, and monitoring of the medication. B. defining appropriate indications for use; . 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications or accept professional standards and principles of the professional(s) providing services.<br><br>On 7/8/24 at 3:23 PM, Surveyor observed RN D prepare the following medications for R46: Carvedilol 3.125 mg (milligrams) tablet, surveyor observed the instructions on the bubble pack indicated one tab by mouth twice a day with meals. Hydrocortisone 10 mg tablet surveyor observed the instructions on the bubble pack indicated once a day by mouth daily at 8 AM Surveyor observed RN D break the Hydrocortisone tablet in half prior to placing the half tab into the medication cup. Surveyor asked RN D about the bubble pack saying 8 AM and breaking the tab in half, RN D replied, it says 5 mg at 2 o ' clock, that's why I broke it in half RN D entered R46's room and administered medications to R46.<br><br>On 7/8/24 at 3:37 PM, Surveyor asked RN D to look at the medication card for R46's Carvedilol, RN D stated I will go get him a snack.<br><br>(Of note: RN D did not provide R46 a snack/meal when administering the Carvedilol and RN D broke R46's tablet in half and did not look for the 5 mg dose that was to be given at 2 PM prior to breaking the 10 mg dose in half. R46's 2 PM dose was given at 3:23 PM, which is out of the 1 hour before and 1 hour after time frame for medication administration.)<br><br>R46's Physician orders indicate the following:<br><br>Hydrocortisone tablet; 10 mg; amt (amount): 10 mg; oral Special Instructions: Take 10 mg PO 1x (one time) daily at 8am. Once A Day 08:00 AM (Start date 2/22/24) Diagnosis Peripheral Vascular Disease.<br><br>Hydrocortisone tablet; 5 mg; amt: 5 mg; oral Special Instructions: Take 5mg PO 1x daily at 2pm. Once A Day 2:00 PM (start date 2/22/24)<br><br>(continued on next page) |

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| | 525331 | A. Building<br>B. Wing | 07/11/2024 |

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

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Carvedilol tablet; 3.125 mg; amt: 1 tab; oral Special Instructions: Take 3.125 mg PO 2x daily with meals dx (diagnosis) HTN (hypertension) Twice A Day 8:00 AM and 4:00 PM (Start date 10/11/2023)<br><br>On 7/8/24 at 4:12 PM, Surveyor interviewed ADON C (Assistant Director of Nursing) regarding observation with R46's medication pass. ADON C indicated R46's Carvedilol should be offered with a snack or meal. ADON C indicated medications can be administered 1 hour before or after the ordered time. ADON C indicated the pharmacy sent a 5mg tab, and that RN D should not break a 10 mg tab in half. ADON C indicated you're not sure what dose you're giving when breaking a tab in half and that is the pharmacies job to cut/split medications. ADON C indicated these are both medication errors and he will start education immediately. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434<br><br>Based on observation, interview, and record review, the facility did not ensure residents are free of significant medication errors for 2 of 2 Residents out of a total sample of 16 Residents (R7 and R18).<br><br>R7 had an order for Midodrine (medication used to constrict blood vessels to increase blood pressure) 5 mg (milligrams) to be administered three times per day by mouth and to hold this medication for a systolic blood pressure over 130. This medication was administered with a systolic blood pressure over 130.<br><br>R18 did not receive nighttime medications on 6/16/24. R18 did not receive insulin per ordered on 6/16/24.<br><br>Evidenced by:<br><br>The facility policy titled, Administering Medications, dated 4/19, states, in part; .Medications are administered in a safe and timely manner, and as prescribed. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .<br><br>Example 1:<br><br>R7 was admitted to the facility on [DATE], and has diagnoses that include Multiple Sclerosis, Pressure Ulcer of sacral (at the bottom of the spine) region, stage 4, Paraplegia, Autonomic Dysreflexia (syndrome in which there is a sudden onset of excessively high blood pressure), Severe sepsis with septic shock (is a life threatening reaction to an infection), Metabolic encephalopathy (brain dysfunction caused by issues with metabolism), and Neuromuscular dysfunction of bladder (condition where the bladder lacks control due to nerve or muscular problems.).<br><br>R7's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/31/24, indicated that R7 has a Brief Interview for Mental Status (BIMS) of 15 indicating that he is cognitively intact.<br><br>R7's Physician Orders, with a start date of 2/6/24, indicates: Midodrine 5 mg tablet - three times a day - 1 tab, oral, Three Times A Day, Take 1 tab PO (by mouth) 3x daily, HOLD if systolic (blood pressure while the heart is contracting, indicated by the top number) BP (blood pressure) over 130.<br><br>R7's Medication Administration Record (MAR) indicates that staff administered Midodrine with a systolic blood pressure over 130 at the following times:<br><br>4/13/24 at 4:00 PM- Administered with a blood pressure of 146/81<br><br>6/26/24 at 8:00 AM- Administered with a blood pressure of 155/85<br><br>6/29/24 at 8:00 AM- Administered with a blood pressure of 136/90<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 7/1/24 at 8:00 AM- Administered with a blood pressure of 132/88<br><br>7/4/24 at 8:00 AM- Administered with a blood pressure of 144/78<br><br>This resulted in five significant medication errors.<br><br>Of note: on 7/9/24 at 8:00 AM- Administration marked refused with a blood pressure of 135/89<br><br>On 7/10/24 at 3:55 PM, Surveyor observed R7 approach RN (Registered Nurse) O and request his 4:00 medications. R7 advised RN O that he had his own automatic blood pressure device and went to his room to retrieve it. Upon his return, R7 placed the automatic blood pressure device on his own arm and activated the device. Surveyor observed that the blood pressure reading was 136/90. R7 stated this reading out loud and the RN O asked to see the device to confirm the reading. After confirming the reading, RN O placed R7's medications into a small medication cup and handed the cup to R7. R7 examined the pills in the cup and advised RN O that he was not supposed to take the Midodrine because his blood pressure was too high. RN O immediately retrieved the medication cup from the resident, apologized, and removed the Midodrine from the cup before returning the cup to the resident. R7 then self-administered his medications.<br><br>Of note: This observation brings the total to 6 significant medication errors between 4/13/24 and 7/11/24.<br><br>On 7/10/24 at 4:31 PM, Surveyor interviewed RN O. Surveyor asked RN O what the process is for administering medications with an ordered parameter. RN O states that if the medication requires that vitals need to be entered, the MAR automatically takes them to a screen to enter the vital signs. RN O also states that the MAR does not flag or alert the user if the vital sign is outside of ordered parameters. Surveyor asked RN O if there is a parameter for R7's Midodrine medication. RN O states that yes, the order is to hold the Midodrine for a systolic blood pressure over 130, and R7's at that time was 136. Surveyor asked RN O if the Midodrine should have been administered. RN O states that it should not have been administered, and that she removed the medication once it was brought to her attention.<br><br>On 7/10/24 at 4:34 PM, Surveyor interviewed DON (Director of Nursing) B. Surveyor asked DON B what the process is for administering medications with an ordered parameter. DON B states that typically staff check the blood pressure before administering the medication and whatever vital sign is ordered needs to be entered before the medication administration can be completed in the computer. Surveyor asked DON B if she would expect staff to follow ordered vital parameters. DON B indicates that she would, however she would like to note that R7 has his challenges and can be uncooperative with cares. Surveyor asked DON B if she would expect R7's Midodrine to be held for a systolic blood pressure over 130. DON B indicates she would expect that medication to be held for a systolic blood pressure over 130.<br><br>44552<br><br>Example 2:<br><br>R18 was admitted to the facility on [DATE] with a diagnoses including heart failure, vascular disease, diabetes, and respiratory failure.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R18's most recent MDS (Minimum Data set) with ARD (assessment reference date) of 5/29/24, indicates R18 has a BIMS (Brief interview of mental status) score of 15 indicating R18 is cognitively intact.<br><br>R18's MAR, states, in part; .Lantus Solostar U-100 Insulin pen; 100 unit/ml (3ml (milliliter)); amount to administer: 20 units; subcutaneous .frequency at bedtime .inject 20 units under skin once daily at bedtime for type 2 diabetes mellitus .start date 5/28/24 .6/16/24 8:00 PM .charted date 6/17/24 3:33 AM Reasons: Not administered .<br><br>On 7/10/24 at 11:00 AM, R18 indicated she did not receive her nighttime medications on 6/16/24.<br><br>On 7/11/24 at 7:25 AM, RN Q (Registered Nurse) indicated she was the RN that discovered R18's nighttime medications were not signed out on 6/16/24. RN Q does not remember if she notified DON B. RN Q indicated she documented directly on R18's MAR, documentation does not support vs were completed by pm shift . RN Q indicated she had to document a note because everything shows up in red on the MAR when documentation is not completed. RN Q indicated she did not call the RN to verify if the medications were given. RN Q indicated she does not remember if R18 reported to her that she didn't get her medications. RN Q indicated R18 will report if she doesn't get medications or has any concerns.<br><br>On 7/11/24 at 9:23 AM, DON B (Director of Nursing), indicated if a nurse finds that medications from a previous shift have not been signed out that nurse should make a note in the progress notes and call the responsible nurse to ensure that the medications were given. DON B indicated if the medication is not signed out that means the medication was not given. DON B indicated DON B was unaware that R18's medications for 6/16/24 HS (night time medications) were not signed out. DON B indicated this would be considered a medication error. DON B indicated she would look back to double check if she was notified and will follow up with Surveyor.<br><br>On 7/11/24 at 10:17 AM, NHA A (Nursing Home Administrator) indicated that medications need to be signed out on the MAR to be considered given to the resident. NHA A expressed understanding regarding the concern with R18's night time medications on 6/16/24.<br><br>On 7/11/24 at 2:42 PM, DON B indicated she was not aware that R18's nighttime medications were not signed out on 6/16/24. DON B indicated it does not appear that R18 received insulin that night per R18's documentation on MAR. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>50285<br><br>Based on observation, interview and record review the facility did not ensure that the ice machine was cleaned and disinfected properly. This has the potential to affect all 56 residents.<br><br>On 7/8/24, Surveyor observed a layer of black film on the inside of the ice machine lid.<br><br>Evidenced by:<br><br>Facility Ice Machine Policy dated 2/22 with last revision date of 1/24 states in part: Ice Machine and Equipment will be cleaned and sanitized on a regular basis .Maintenance will deep clean the ice machine quarterly and as needed .<br><br>On 7/8/24 at 9:02 AM, during the initial tour of the kitchen, Surveyor and Dietary Manager (DM) F observed a layer of black film on the inside lid of the ice machine in the right-hand corner.<br><br>DM F indicated that maintenance was responsible for cleaning the air filter, but she was unsure who was responsible for cleaning the ice machine itself. DM F stated that they do not contract with an outside source to clean the ice machine.<br><br>On 7/10/24 at 9:09 AM, Surveyor interviewed Maintenance Director G, who indicated he was unsure if anyone comes and cleans out the ice machine on a regular basis. Maintenance Director G indicated he was unaware of any outside vendor that came in to clean or service the ice machine. Maintenance Director G stated that he will randomly clean it when he has time.<br><br>On 7/10/24 at 4:34 PM, DM F indicated that maintenance is responsible for cleaning and maintaining the ice machine. DM F indicated that the expectation is that the ice machine would be cleaned and sanitized on a regular basis.<br><br>The facility ice machine was not properly cleaned and sanitized, resulting in a black film accumulating inside the ice machine lid, which may lead to harmful health conditions if ingested by the residents.<br><br>44552<br><br>On 7/10/24 at 9:00 AM, MD G (Maintenance Director) MD G indicated he will clean the ice machine and replace filter as needed. MD G indicated there is not a set cleaning schedule for the ice machine, but he could set up a reminder to do so. MD G indicated he would expect the ice machine to be clean.<br><br>On 7/10/24 at 2:30 PM, NHA A (Nursing Home Administrator) indicated the facility is getting new ice machines and that he would expect the inside of the ice machines to be clean. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>50285<br><br>Based on observation, interview and record review the facility did not ensure that garbage and refuse was disposed of properly. This has the potential to affect all 56 residents.<br><br>On 7/8/24, Surveyor observed garbage not properly contained in the dumpsters.<br><br>Evidenced by:<br><br>Facility Trash Disposal and Dumpster Area Policy dated 1/22 with last revision date of 1/24 states in part: Garbage will be disposed of as needed throughout the day and at the end of each day .Trash will be deposited into a sealed container outside the premises.The garbage storage area must be maintained in a sanitary condition to prevent the harborage and feeding of pests. Maintenance will routinely check the premises and keep the dumpster area free of debris .<br><br>Example 1<br><br>On 7/8/24 at 9:02 AM, during the initial tour of the kitchen, Surveyor and Dietary Manager (DM) F observed the following outside, on the ground near the facility's main garbage dumpster:<br><br>-Multiple used gloves.<br><br>-Wet cardboard boxes .<br><br>-A pile of food waste.<br><br>-A tub of stagnant brown water.<br><br>-Cigarette butts.<br><br>-Packing peanuts and other miscellaneous debris.<br><br>DM F indicated she was unsure of who was responsible for ensuring garbage was disposed of properly and picking up any trash that fell on the ground.<br><br>On 7/10/24 at 9:09 AM, Surveyor interviewed Maintenance Director G who indicated that it was his expectation that if a staff member dropped a used glove or food on the ground by the dumpster, that they would pick it up and dispose of it properly.<br><br>On 7/10/24 at 4:34 PM, DM F indicated that maintenance is responsible for ensuring garbage is in the dumpster. DM F indicated the expectation is that garbage is put in the dumpster and not laying outside, and that anyone who spills garbage on the ground would pick it up and dispose of it the dumpster.<br><br>Waste was not properly contained in a dumpster resulting in an unsanitary condition which may lead to harboring or feeding of pests.<br><br>(continued on next page) |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 44552<br><br>On 7/9/24 at 9:43 AM, Maintenance I indicated he will sweep and clean up around dumpsters as needed. Maintenance I indicated he would expect if someone sees garbage laying outside the dumpsters that they pick it up and throw it away. Maintenance indicated he has not been outside by the dumpsters today.<br><br>On 7/10/24 at 9:00 AM, MD G (Maintenance Director) indicated it is maintenance responsibility to clean up around the dumpsters. MD G indicated the area around the dumpsters is now cleaned up. MD G indicated he would expect the area around the dumpster to be clean and not have garbage outside the dumpsters.<br><br>On 7/10/24 at 2:30 PM, NHA A (Nursing Home Administrator) indicated he would expect garbage to be picked up around the outside of the dumpster. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>39849<br><br>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. This has the potential to affect all 56 residents (R) in the facility.<br><br>The facility does not maintain a staff infection control line list for illnesses/infections other than Covid-19.<br><br>The facility's policies have not been updated annually.<br><br>This is Evidenced by:<br><br>The Facility's provided the policy, Surveillance for Infections, with a reviewed date of 4/1/24, indicates, in part: Policy Statement - The infection preventionist will conduct ongoing surveillance for health-care associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other prefventative interventions. Policy Interpretation and Implementation - 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment; b. available processes and procedures that prevent or reduce the spread of infections; c. clinically significant morbidity or mortality associated with infection .d. pathogens associated with serious outbreaks .<br><br>Example 1<br><br>On 7/10/24 at 8:49AM, Surveyors completed the infection control interview with ADON/IP (Assistant Director of Nursing/Infection Preventionist) C. Surveyors noted that the only staff listed on the infection control line lists were in relation to covid.<br><br>ADON/IP indicated the facility does not have a staff line list at this time unless they are positive for Covid. ADON/IP indicated that he keeps a call-in log in a spreadsheet and reviewed this with surveyor. The call-in log has staff names, listed alphabetically, in the first column and then each column after the staff name has a call in date and, in some instances, limited information on symptoms, when it is included at all. There is no information regarding last date worked, date symptoms started/resolved, return to work date, and/or type of infection.<br><br>Of note, without an accurate staff line list or staff call-in process to ensure appropriate signs and symptoms of illness are known, it is unclear if staff were excluded from work appropriately to prevent the spread of potential communicable illnesses.<br><br>Example 2:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The following facility Infection Prevention and Control policies have not been reviewed annually:<br><br>*Legionella Water Management Program policy has a Revised date of September 2022.<br><br>*Coronavirus Disease (COVID-19) - Vaccination of Residents policy has a Revision date of May 2023<br><br>*Coronavirus Disease (COVID-19) - Vaccination of Staff policy has a Revision date of June 2023.<br><br>On 7/10/24 at 8:49 AM, Surveyors completed the infection control interview with ADON/IP (Assistant Director of Nursing/Infection Preventionist) C and asked how often Infection Control Polices should be reviewed. ADON/IP indicated annually.<br><br>Surveyors reviewed above polices with ADON/IP who indicated that he would see if there were more updated versions of the policies.<br><br>On 7/10/24 at 12:00 PM, ADON/IP informed surveyor he was not able to find any further updates to the above polices and the policies provided above are the most recent dates. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849<br><br>Based on interview and record review the facility must develop policies and procedures to ensure that residents and/or resident responsible party receives education regarding the benefits and potential side effects of the immunization prior to offering the immunization and documentation is noted in the medical record on whether the resident received or declined the immunization, this affected 1 of 5 residents (R41) reviewed for pneumococcal immunizations.<br><br>R41 received the Pneumococcal 23 vaccine on 7/5/22. R41 became eligible for further pneumococcal vaccinations one year after this date and was not offered the additional vaccines by the facility.<br><br>Evidenced by:<br><br>The facility's policy, titled, Pneumococcal Vaccine, with a revised date of, October 2023, states, in part: Policy Statement - All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation - 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series .7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.<br><br>The PneumoRecs VaxAdvisor application recommendation for R41 is as follows:<br><br>Give 1 dose of PCV15 (pneumococcal conjugate vaccine) or PCV20 at least 1 year after the last dose of PPSV23 (pneumococcal polysaccharide vaccine). Regardless of which vaccine is used (PCV 15 or PCV 20), their pneumococcal vaccinations are complete.<br><br>(PneumoRecs VaxAdvisor is a standalone application. It provides patient-specific guidance consistent with the immunization schedule recommended by the U.S. Advisory Committee on Immunization Practices (ACIP). CDC releases guideline changes and enhancements to the app itself through app updates.)<br><br>R41 has a current admitted [DATE], with diagnoses that include in part: Chronic respiratory failure with hypoxia (low oxygen), Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation (abnormal heartbeat).<br><br>On 7/9/24, Surveyor reviewed R41's immunization record as part of the overall infection control task and noted R41 received the Pneumococcal 23 vaccine on 7/5/22. According to CDC (Centers for Disease Control and Prevention) recommendations, R41's should have been offered a dose of the Pneumococcal 15 or Pneumococcal 20 vaccine at least 1 year after the last dose of Pneumococcal 23.<br><br>On 7/9/24 at 2:09 PM, Surveyor was provided R41's WIR (Wisconsin Immunization Registry) report from the facility. This document also noted R41 received the Pneumococcal 23 vaccine on 7/5/22 and does not indicate any other Pneumococcal vaccinations have been administered.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525331 | A. Building<br>B. Wing | 07/11/2024 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/10/24 at 9:39 AM, Surveyor asked ADON/IP C (Assistant Director of Nursing/Infection Preventionist) what the process is to track eligibility for vaccines if resident's are not eligible on admission, but become eligible during their stay. ADON/IP C indicated currently he looks in WIR every few months as that is where he is getting his flags for vaccination due dates.<br><br>On 7/10/24 at 10:01 AM, Surveyor interviewed ADON/IP C and reviewed R41's WIR report and R41's immunization documentation in the facility electronic health record. ADON/IP C agreed that R41 was eligible for and should have been offered another pneumococcal immunization after 7/5/23 and R41's physician should have been contacted at that time for their recommendation. |