STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525064	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove New Berlin	13755 W Fieldpointe Dr New Berlin, WI 53151

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not thoroughly investigate an allegation of abuse or neglect affecting 1 (R3) of 3 Facility Reported Incidents reviewed. R3 was found to have a large bruise to the back of the base of the neck. Staff members that cared for R3 were not interviewed to determine the cause of the bruise. Administration interviewed other residents to determine if they had safety concerns; no residents from R3's unit or floor were interviewed. The report that was filed with the State Agency documented conflicting dates of when the injury of unknown origin was discovered. Findings include: The facility policy and procedure titled Comprehensive 'Abuse', Neglect, Mistreatment and Misappropriation of Resident Property Program dated 11/8/2023 documents: E. INVESTIGATION: ABUSE POLICY REQUIREMENTS: It is the policy of this facility that reports of abuse are promptly and thoroughly investigated through the organization's QAPI (Quality Assurance and Performance Improvement) Incident Report and Investigation process. PROCEDURE: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of Abuse: When an incident or suspected incident of abuse is reported, the Executive or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe the resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. iii. Resident's roommate statements (if applicable) iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vi. Injuries present including an [sic] resident assessment vii. Observation of resident and staff behaviors during the investigation viii. Environmental considerations . b. Investigation of injuries of Unknown Origin or Suspicious Injuries: must be immediately investigated to rule out abuse: i. Injuries include, but are not limited to, bruising of the inner thigh, chest, face, breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma. R3 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following an intracerebral hemorrhage affecting the left side, dysphagia (difficulty swallowing), aphasia (inability to speak), chronic obstructive pulmonary disease, and epilepsy. R3's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R3 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 and had impairment to both arms and legs. R3 was admitted to hospice services on 4/28/2025. The Functional/Rehabilitation Potential Care Area Assessment (CAA) with the Significant Change MDS documented R3 used a full mechanical lift for transfers and was dependent with all activities of daily living. R3 had been hospitalized for a stroke and now had elected hospice services. R3's Power of Attorney (POA) had been activated. On 5/12/2025, at 9:45 AM, in the progress notes, the wound Nurse Practitioner documented R3 had a new abrasion to the lower back that was noted on exam that morning and staff had noted a new skin tear to the left elbow. The left elbow skin tear measured 0.5 cm (centimeters) x (by) 0.7 cm x < (less than) 0.1 cm and the low back abrasion measured 4 cm x 0.5 cm x <0.1 cm. On 5/12/2025, at 10:00 AM, in the progress notes, Registered Nurse (RN)-D documented R3 had a skin tear to the left elbow and an abrasion to the lower back. RN-D documented the same measurements as the wound Nurse Practitioner. RN-D applied treatments to both wounds. On 6/26/2025, at 11:30 AM, Surveyor asked RN-D how R3 sustained the abrasion to the lower back. RN-D stated RN-D was with the wound Nurse Practitioner doing wound rounds and that is when the abrasion was discovered. RN-D stated they determined the abrasion was caused by friction in bed when R3 was being pulled up in bed or repositioned. RN-D stated it was a small area. On 5/12/2025, at 3:46 PM, in the progress notes, Licensed Practical Nurse Supervisor (LPN Sup)-N documented R3 had discoloration and skin tears to the upper back. LPN Sup-N documented LPN Sup-N was informed by the floor RN that R3 had purplish/reddish discoloration and skin tears to the upper back right below the neck. LPN Sup-N observed the reddish purple discoloration to the area where R3's neck meets the back as well as two skin tears. The area was cleansed, and a foam border was applied. R3 was assessed for pain. R3's POA, hospice and Nurse Practitioner were notified. On 5/12/2025, at 3:46 PM, in the progress notes, RN-O documented R3 was found with a large, bruised area behind the neck with three small open areas on the right in the wound. The wound was cleaned with normal saline and Mepilex was applied. RN-O updated LPN Sup-N with the information and R3's POA and hospice were notified. Surveyor noted there was no documentation of the measurement of the bruise or open areas and the documentation by LPN Sup-N indicated there were two open areas while RN-O indicated there were three open areas. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3 passed away on 5/15/2025 at the facility on hospice services. Surveyor reviewed the facility investigation of R3's injury of unknown origin. Nursing Home Administrator (NHA)-A documented and signed the summary of the investigation. NHA-A documented on 5/13/2025, R3 was visited by the Nurse Practitioner early in the day for a routine exam. No bruise was noted. By the afternoon, R3 was discovered to have a bruise at the base of the neck, about the size of an apple. R3 was not their own person and was not able to tell NHA-A what happened. Surveyor noted the bruise was documented to have been found on 5/12/2025 and not 5/13/2025. Surveyor noted the summary was the first time an approximation of size was given for the bruise: the size of an apple and did not include open areas in the same location as the bruise. Surveyor noted the Nurse Practitioner that saw R3 was the wound Nurse Practitioner. The Findings of Investigation documented by NHA-A indicated staff on all three shifts and different departments were interviewed. Surveyor noted the staff that were interviewed were Director of Nursing (DON)-B, LPN-P, and seven Certified Nursing Assistants (CNAs). DON-B's statement documented DON-B was made aware of R3's bruise from the incident report and did not state DON-B saw R3's bruise. LPN-P was working the day shift and caring for R3 on 5/12/2025. LPN-P's statement documented LPN-P did not know anything about a bruise until 5/14/2025 through conversation with RN-D. A CNA working on day shift 5/12/2025 on R3's unit and a CNA working on pm shift 5/12/2025 on R3's unit were interviewed; neither CNA was assigned to care for R3 on that day and had no knowledge of the injury of unknown origin. None of the staff interviewed had physical contact with R3 on 5/12/2025, the day the injury of unknown origin was discovered. Three residents were interviewed to determine if they felt safe in the facility or had any concerns about care. They denied any concerns. Surveyor noted the residents interviewed were on a different unit and a different floor from R3's unit so encountered different staff which would not rule out potential abuse by staff members that were caring for R3. NHA-A documented the police department was notified, and a case number was provided with a statement the police did not want to further follow the case. On 6/25/2025 at 2:18 PM, Surveyor called the police department (PD) and spoke to PD-Q to verify the police were contacted. PD-Q looked up the case number provided and the incident with that case number was a neighbor dispute for dogs barking. The case number had a date of 5/17/2025. PD-Q looked up all records for 5/2025 using R3's name and birthdate as well as any calls placed by the facility's address. No calls matched the description of the injury of unknown origin sustained by R3. NHA-A documented that based on the investigation, the facility could reasonably determine the bruise was likely from the Hoyer sling during the shower on 5/11/2025. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/26/2025, at 8:37 AM, Surveyor asked NHA-A who does the investigation for an injury of unknown origin. NHA-A stated Assistant NHA (ANHA)-C gets the statements from staff and residents and then brings them to NHA-A and together they discuss and determine what happened. Surveyor noted all the staff and resident statements for R3's investigation of the injury of unknown origin was signed by ANHA-C. Surveyor asked ANHA-C how ANHA-C determines what staff should be interviewed for an investigation of an injury of unknown origin. ANHA-C stated ANHA-C tries to get a mix of day and pm shift staff and NHA-A gets interviews from the night shift. ANHA-C stated the staff are randomly picked with a focus on the unit the event happened on and then spread out to other units. Surveyor asked ANHA-C why an investigation is done. ANHA-C stated an investigation is trying to get to the bottom of why the incident occurred, looking at the resident cares and how they transfer. Surveyor asked ANHA-C if an injury is determined to be caused by a transfer, does ANHA-C look at the resident being transferred or try to recreate the event. ANHA-C stated no, ANHA-C would interview the next staff member and look at the resident's care plan. NHA-A stated CNA-E is the facility transfer expert, so CNA-E does all the training for transferring residents with lifts. NHA-A stated the interdisciplinary team has a conversation to determine if there is a trend in the facility and then education and training is provided either by CNA-E or a computer-based program. Surveyor asked ANHA-C how it was determined that the bruise came from the full mechanical lift transfer at the time of the shower the day before. ANHA-C stated through staff interviews, R3 was difficult to maneuver and most likely came from the Hoyer lift during the shower on 5/11/2025. NHA-A stated CNA-E said it was hard to determine, but the shower sling was the most likely cause. Surveyor reviewed CNA-E's statement to ANHA-C on 5/15/2025: CNA-E and two other CNAs gave R3 a bed bath on 5/10/2025 and did not notice any bruise behind the neck. Surveyor noted CNA-E did not have any other statement showing CNA-E researched how R3 was transferred, if the sling rested on the back of R3's neck, or if CNA-E was involved in any part of the investigation. Surveyor shared with NHA-A and ANHA-C the concerns the report submitted to the State Agency had a date of 5/13/2025 when the incident happened on 5/12/2025, none of the staff that were interviewed regarding R3's injury of unknown origin had cared for R3 on 5/12/2025, there was no physical investigation with the use of the sling and lift with R3 to determine if a bruise could have reasonably developed to the back of the neck, and the three residents interviewed for follow-up abuse concerns were not on R3's unit or floor and did not encounter the same staff as R3. Surveyor shared with NHA-A and ANHA-C the concern the bruise itself was not assessed; there were no measurements of the bruise to provide detail of size and there was conflicting documentation in the progress notes as to if there were two or three open areas within the bruising. In an interview on 6/26/2025, at 9:25 AM, Surveyor asked DON-B if DON-B was involved in the investigation of R3's injury of unknown origin. DON-B stated once the injury becomes a self-report, DON-B is not involved in the investigation. DON-B stated NHA-A does all the interviews and gets all the data. In an interview on 6/26/2025, at 11:30 AM, Surveyor asked RN-D if any bruising was noted to R3's upper back or base of the neck when doing wound rounds with the wound Nurse Practitioner on the morning of 5/12/2025. RN-D stated RN-D did not see any bruise on R3 at that time. RN-D stated RN-D heard about the bruise to R3's back of the neck later but was never interviewed about any observations RN-D made of R3.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 2 (R1 and R2) residents reviewed for accidents. R1 was care planned to transfer with a sit to stand mechanical lift and assist of 2 staff. CNA's transferred the resident with 2-person pivot. R1 sustained a leg fracture.R2 was care planned to transfer with a sit to stand mechanical lift and assist of 2 staff. The CNA transferred the resident alone. R2 sustained a fall from the sit to stand resulting in a head laceration requiring staples.Findings include:R1 admitted to the facility on [DATE] and entered onto Hospice [DATE]. Diagnoses included Atrial Fibrillation, Heart Failure, Peripheral Vascular Disease, Dementia, anxiety, Osteoporosis and Pulmonary Hypertension. R1 passed away at the facility on [DATE].R1's Care Plan documented: The resident has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) activity intolerance, limited mobility - initiated [DATE]. Interventions include: Transfer: The resident requires Mechanical Lift sit to stand with 2 staff assist for transfers, May use Hoyer lift as needed when resident not tolerating the sit to stand lift - initiated [DATE] revised [DATE]. The facility does not have a policy and procedure specific to mechanical lifts. Surveyor was provided the facility policy and procedure with the subject Safe Individual Handling Program which documents (in part) A. Transfer assessment1. Individuals will be assessed according to ability per transfer and movement objective criteria. Nursing will perform this assessment in collaboration with therapy as applicable.2. Once the assessment is completed, the appropriate transfer status will be determined.B. Care Plan1. Individual-specific transfer status will be addressed on the Care Plan to include specific equipment type if applicable.2. All staff to transfer according to the Care Plan unless it is determined by the Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Certified Nursing Assistant (CNA) at the time that the transfer is not a safe transfer for either the individual or the staff member. On [DATE] at 9:42 PM, R1's progress notes included an Einteract change in condition (CIC) form completed by Licensed Practical Nurse (LPN)-G which documented: New or Worsening Pain. Nursing observations, evaluation, and recommendations are: When resident being transferred to bed. She stated that she was having pain in her left ankle from the transfer. Residents' bilateral ankles and feet are swollen 4+ pitting edema. No redness or bruising noted to the left ankle. On [DATE] at 12:06 AM, LPN-H documented: C/O (complained of) increased pain to left ankle / foot. Left ankle, foot appears swollen red pain to touch. Resident requested to go to the hospital. PRN (as needed) Morphine administered resident appears anxious update PRN Lorazepam administered. (Hospice) called at midnight requesting X-ray to left ankle left arm. Awaiting call back. On [DATE] at 12:19 AM, Hospice nurse out to evaluate resident.On [DATE] at 2:52 AM, Hospice Registered Nurse (RN)-I documented: Received a call stating that (LPN-H) called to report that pt (patient) is calling out in pain. States that pt said that she was pivot transferred into bed and her ankle hurts. Call placed to (LPN-H) who states per pt was pivot transferred to bed and is complaining of L (left) ankle pain and pt want to go to the hospital. (LPN-H) is requesting an X-ray. Writer will visit and assess pain. Arrived to pt room, pt moaning. Writer, I talked with pt and asked pt where her pain was and she stated, all over. Pt has L shoulder pain which is chronic. Upon assessment pt LLE (left lower extremity) swollenness 4+ pitting edema Knee to foot. L ankle pain when touched. L calf to ankle red hot to touch. Pt with 4+ pitting edema LLE. RLE (right lower extremity) 2+ pitting edema. Slight redness noted to inner side of calf near ankle. Pictures sent to (Physician). Orders received for Cephalexin 500 mg (milligrams) BID (twice daily) x 7 days. Pt was given morphine 10 mg x 2 and lorazepam 0.5 mg x1. Pt comfortable and sleeping at end of visit.On [DATE] at 10:59 AM, Surveyor spoke with Hospice Nurse-I who reported she spoke to the Physician and sent pictures. Hospice Nurse-I stated, It appeared to look like cellulitis, so he ordered an antibiotic. Surveyor confirmed with Hospice Nurse-I that she was aware the resident was pivot transferred into bed and complained of pain after. Surveyor asked if she notified the Physician. Hospice RN-I stated she did not recall if she notified the Physician that R1 was transferred incorrectly by pivot instead of the sit to stand and was complaining of pain after. Surveyor located no evidence the Physician was notified. On [DATE] at 7:51 AM, progress notes document: Resident has c/o pain to the left leg and foot, rating it 10/10. Slightly relived by MSO4 (Morphine). Resident screaming upon staff gently moving her leg. Writer placed a call to (Hospice) and received orders for a X-ray. On [DATE] at 8:46, Biotech here to do X-rays. On [DATE] at 9:40 AM, RN Hospice here to see this resident. Resident continues to c/o pain, stating that it is not cellulitis pain it is something different and more painful. MSO4

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2) R2 was admitted to the facility on [DATE] with diagnoses that include, Alzheimer's disease, dementia, arthritis, spinal stenosis, osteoporosis, muscle weakness, paraplegia and anxiety disorder. R2's annual Minimum Data Set (MDS) assessment, dated [DATE], documents R2 has a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. A Patient Health Questionnaire (PHQ-9) score of 0, indicating no depressive symptoms, and no indicators of psychosis including no hallucinations or delusions. R2 is assessed to require substantial/maximal assistance for transfers from chair to bed. R2's Care Area Assessment (CAA) documents, R2 is triggered for falls due to use of antidepressants. Risk factors: incontinence, paraplegia, visual, hearing, cognition, and anxiety. R2's Care Plan, date initiated [DATE], documents, Focus: R2 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) weakness, pain, dementia. Interventions include, R2 requires sit to stand lift with 2 staff assistance for transfers; date revised [DATE]. R2's CNA (Certified Nursing Assistant) Kardex dated [DATE], documents, Transfer: requires sit to stand lift with 2 staff assistance for transfers. R2's Progress Note, dated [DATE] at 19:13 (7:13 PM), documents, Note Text: The CNA reported to the floor nurse that the resident fell while using the sit to stand lift, striking the back of her head and briefly losing consciousness. Due to active bleeding, 911 was called, and the resident was transferred to [Hospital]. The POA (Power of Attorney], on-call manager, DON (Director of Nursing) and [On call Physician Group] were all notified. R2's Progress Note, dated [DATE] at 21:17 (9:17 PM), documents, NP (Nurse Practitioner) notified, pt (patient) sent to hospital post fall. Patient POA (Power of Attorney) notified of pt post fall. R2's Hospital emergency room summary, dated [DATE], documents, .Scalp: 2 cm (centimeter) laceration to the back of R2's head, bleeding was controlled prior to arrival. Significant amount of dried blood. Face: Abrasion to left temple, no bleeding. Left Upper Extremity: Multiple ecchymosis around the elbow.CT head: No acute findings or interval change intracranially. New small right posterolateral scalp, laceration/hematoma without skull fracture.Diagnosis: Laceration. Imaging of head and neck were negative for trauma. Laceration was repaired with 2 staples. R2's Physician orders, start date, [DATE], Laceration care to the right side of the skull, gently wash with NS (Normal Saline) to keep clean, end date [DATE]. R2's Physician orders, start date, [DATE], Monitor for S/S (Signs and Symptoms) of concussion: HA (headache) and the severity, change in mentation or behavioral changes. Chart in progress notes, end date, [DATE]. R2's Physician orders, start date, [DATE], may use ice pack to right back of head for pain relief, end date [DATE]. R2's Progress Note, dated [DATE] at 00:17 (12:17 AM) documents, Resident returned at approx (approximately) midnight. She had 2 staples placed to the laceration on the back of her head. AMS (Altered Mental Status) is at her baseline. Resident denies pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed the facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report, dated [DATE] and completed by Nursing Home Administrator (NHA)-A, which documents . Allegation Type: Injury of unknown source: Injury was not observed and is suspicious because of extent or location. Brief Summary: Resident is not her own person. Resident had a fall over the weekend and went to the hospital with a laceration to her head. Resident has now admitted back to the facility with 2 staples in her head as a treatment for the laceration. Full investigation underway. Self-reporting as a fall with major injury. The facility Misconduct Incident Report, dated [DATE], included a summary completed by NHA-A, which documents, .Certified Nursing Assistant (CNA)-R noted that during resident transfer, around 7:30 PM, resident slipped out of the sling and she fell to the ground. CNA-R then grabbed RN-S and CNA-E. R2 was transferred to the ER (Emergency Room) and returned to the facility with two stitches/staples. Aide was following care plan and process, no issues. This was an accident. Surveyor notes, care plan was not followed as the care plan documents, R2 requires sit to stand lift with 2 staff assistance for transfers and only 1 CNA was assisting R2 when she slid from the sit to stand mechanical lift. The facility Investigation Report dated [DATE], and completed by Licensed Practical Nurse (LPN) Supervisor-N, documents Summary of Alleged Incident: R2 witnessed fall on [DATE]. The resident's CNA (Certified Nursing Assistant) reported to the floor nurse that the resident experienced a fall while using the sit-to-stand lift during a transfer from a sitting to standing position. During the fall, the resident struck the back of her head on the ground and briefly lost consciousness but quickly regained awareness. Due to visible bleeding from the occipital area, staff made the decision not to move the resident and immediately called 9-1-1. The resident was unable to recall the incident. EMS (Emergency Medical Services) responded promptly, and the resident was transferred to [Hospital] for evaluation. The resident's family, on-call manager, Director of Nursing, and [on call physician group] were all notified and updated accordingly. Following her return from the Emergency Room, the resident was noted to have received two staples to the back of her head. She was placed on a 24-hour observation board with neuro (neurological) checks initiated per protocol. Pertinent diagnoses include age-related Osteoporosis; Alzheimer's Disease; Dementia in Other Diseases; Paraplegia, Spinal Stenosis. The IDT (Interdisciplinary Team) reviewed the fall and determined that the root cause was the resident losing her balance during a transfer, likely due to her underlying diagnosis. The care plan was updated with PT/OT (Physical Therapy/Occupational Therapy) to evaluate and treat for transfers. CNA-R completed a Written Statement dated [DATE], which documents, I went into R2's room to put her into bed around 7 PM 06/06. I put her on the sit to stand and was about to put her into bed but she slipped out of the sling. She hit the floor, I tried to call her name but I got no response. I went get a nurse and she called 911. I was not aware that I needed a second person with a sit to stand. On [DATE], Surveyor interviewed R2, who stated she just cannot remember what happened when she fell. R2 stated she feels safe at the facility, and no one has ever hurt her. On [DATE] at 11:12 AM, Surveyor interviewed DON-B, who stated, R2 was a sit to stand lift with assist of 2 prior to fall on [DATE]. DON-B stated, R2's fall occurred because her legs gave out and she slid out of the sling and out of lift. R2 was getting ready for bed with CNA-R. DON-B stated, Therapy reassessed R2 after the fall and determined R2 did not have the strength for a sit to stand lift and now uses a Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:12 PM, Surveyor interviewed DON-B who when asked about how the CNA's know what sling size to use for each resident who uses a sit to stand and DON-B stated, there are charts on each unit by the linen carts that goes by weight of resident. Surveyor asked if sling sizes are on the Kardex for the CNA's and DON-B stated, no we have not put the sling sizes on the Kardex. Surveyor asked DON-B if the sling size is charted anywhere for the CNA's and DON-B stated, no. Surveyor asked DON-B what the expectation of a CNA before a resident is transferred and DON-B stated, Typically, there is a sling in each resident's room that uses a sit to stand lift. The slings are not labeled per resident, but each resident should have their own sling. DON-B stated, if there is not a sling in the resident's room, the CNA will check the weight chart for the appropriate size. Surveyor asked DON-B if there has been any training post fall on [DATE] regarding how to determine sling size, how to attach sling to sit to stand lift and resident safely and DON- B stated, no. On [DATE] at 2:22 PM, Surveyor interviewed CNA-E, who also works as the Scheduler and Transfer Mobility Coach. Surveyor asked CNA-E what she recalls from the evening of R2's fall on [DATE]. CNA-E stated that CNA-R was running past her office in a panic and CNA-E asked CNA-R what was going on. CNA-R told CNA-E, R2 fell, and she needed to find a nurse. CNA-E located both RN-S and RN-U and everyone went to R2's room. CNA-E stated, R2 was lying on the floor, face up. 911 was called and together, the RN-U and RN- S did a complete assessment. RN-S asked R2 what happened, and R2 could not recall. RN-S asked CNA-R what happened, and CNA-R, stated R2 slipped out of sit to stand lift and CNA-R was transferring R2 by herself. CNA-E stated, that with the sit to stand being used for R2, it can be an assist of 1. CNA-E stated, R2's Kardex indicates a sit to stand lift but CNA-E did not know if Kardex stated assist of 1 or 2. CNA-E stated she provided CNA-R with an additional 8 hours of orientation, training on mechanical lifts, and lift observations with CNA-R post R2's fall on [DATE]. On [DATE] at 2:35 PM, Surveyor interviewed CNA-R. Surveyor asked CNA-R what she recalls from the evening of R2's fall on [DATE]. CNA-R stated, R2 was being transferred in the sit to stand lift. CNA-R had sling around R2's waist and it was buckled in front. R2 had on non-skid socks on her feet. CNA-R stated, when R2 was in the standing position, R2 became weak and slipped out of the sling. R2's arms went up and the sling went over her head, and she slipped out. CNA-R stated she tried to catch R2 but it happened fast and R2 fell to the floor and hit her head. CNA-R stated she was alone when she did the transfer for R2. CNA-R stated she was aware the Kardex documented R2 required a sit to stand lift and did not remember if the transfer needed a 1 or 2 staff assist or what sling size was needed. On [DATE] at 2:45 PM, Surveyor interviewed CNA-T, who stated, she will generally find sling size on care plan, if not found on care plan, CNA-T goes to Kardex. Surveyor asked CNA-T if she could show an example of a sling size on a Kardex and CNA-T could not find any evidence of sling size on a Kardex. CNA-T stated, there are not slings in each resident's room for a sit to stand lift, only for Hoyer lifts. The slings are in the hallway by the linen carts. Surveyor asked CNA-T if she knew how to determine sling size and CNA-T stated, if she already does not know, she would then ask the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525064	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove New Berlin	13755 W Fieldpointe Dr New Berlin, WI 53151

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 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:12 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A, who stated on [DATE], the facility purchased all new sit to stand lifts. NHA-A stated, the manufacturer guidelines say that the new sit to stand lifts can either be an assist of 1 or 2 staff. NHA-A stated, on [DATE], following R1's fall, training occurred for staff that all sit to stand, and Hoyer lifts should be an assist of 2 staff. NHA-A stated, when R2's fall occurred on [DATE], the facility did an audit of each resident using a sit to stand lift to see each resident's care plan is an assist of 1 or 2 staff and if it matches what the CNA is doing. NHA-A stated, facility then determined if it still met the needs of each resident. Surveyor notes, NHA-A did not provide an audit for the completion of each resident using sit to stand and if it matches care plan after request to review all audits. The only audit provided, documents the review of 2 incident reports related to falls and if the care plan was followed. On [DATE], at 10:35 AM, Surveyor interviewed CNA-E (also Scheduler and Transfer Mobility Coach). Surveyor asked CNA-E what how she knows what sling size to use for each resident and CNA-E stated, there should be a sling in the room for each resident, if not, slings are found on each unit. Surveyor asked CNA-E how she know how much to tighten sling belt and CNA-E stated, adjust the sling belt so that the resident would not slip, the belt would hold up. Surveyor asked how CNA-E would determine if a sling would slip off and CNA-E stated, the sling would not be tight enough. CNA-E stated, it is her assumption this is what happened with the fall with R2 on [DATE]. On [DATE], Surveyor interviewed DON-B who stated R2's legs gave out and this is why she slipped out. If a resident lets go of on sit to stand lift, the arms can slouch right through sling. DON-B stated even if the belt is tightened to a resident's body, the resident can still easily slip out when arms are above head when falling. Surveyor notes, CNA-R was unavailable for interview for questioning on use of sling. On [DATE], at 11:20 AM, Surveyor interviewed NHA-A and asked how the facility determined the method of R2's transfer was done correctly on [DATE]. NHA-A stated, it is safe to say that we assumed it was just the care plan not being followed. Surveyor asked, did you investigate why R2 slipped out of the sit to stand, for example, was the correct sling size used or did the CNA know how to properly hook up and adjust the sling, or if there were two CNA's assisting? NHA-A stated, he did not investigate any of these potential factors. Surveyor notified NHA-A of concern regarding an incomplete investigation to determine the root cause of R2's fall. NHA-A acknowledges there were several other factors to investigate. Surveyor notified NHA-A of concerns regarding R2's care plan not being followed which documents assist of 2 and only 1 staff assisted with the sit to stand transfer. That transfer resulted in R2 slipping from the sit to stand, hitting their head and requiring 2 staples in the ER.