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	09/08/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act, the facility did not report 1 of 2 allegations reviewed for neglect/mistreatment to the State Survey Agency during the required timeframe.R2's daughter sent an email to the Nursing Home Administrator regarding a concern of mistreatment and neglect towards R1. This was delayed in being reported to the state agency.Findings include:The Facility Policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, last reviewed 11/8/23, documents (in part): G. Reporting and ResponseAbuse Policy Requirements:It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, it the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility.R2 was admitted to the facility on [DATE] with pertinent diagnoses that include hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side (a serious neurological condition characterized by paralysis (hemiplegia) or weakness (hemiparesis) on the left side of the body, with the left hemisphere of the brain being dominant), polyneuropathy (the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged. This condition often causes weakness, numbness and pain, usually in the hands and feet), morbid obesity (a condition in which you have a body mass index (BMI) higher than 35. BMI is used to estimate body fat and can help determine if you are at a healthy body weight for your size), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months). R2's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/8/25, documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R2 is cognitively intact . The MDS documents that R2 was assessed to have no behaviors exhibited during the look back period. R2's Patient Health Questionnaire (PHQ-9) score was 00, indicating no depressive symptoms. R2 is coded as making self understood and understands others. Per the MDS, R2 has an impairment on one side for both the upper and lower extremities. The MDS indicates R2 is frequently incontinent of bladder and always incontinent of bowel. On 9/4/25, at 8:52am, Surveyor interviewed R2 about an aide ever stating they were going to take a picture of R2's bowel movement. R2 stated that the Nursing Home Administrator (NHA)-A had talked to R2 about the incident for about 20 minutes, but NHA-A never asked the name of the aide who stated they would take a picture of R2's bowel movement. On 9/4/25, at 10:45am, Surveyor interviewed complainant who stated that on 8/31/25, R2 called and stated an aide had wanted to take a picture of R2's bowel movement. The complainant then emailed NHA-A immediately to alert of the situation. The aide was identified to Surveyor. The email that was sent to NHA-A was forwarded to Surveyor with the time stamp of Sent: Sunday, August 31, 2025 7:41pm.On 9/4/25, at 12:03pm, Surveyor interviewed Nurse Supervisor-O who stated when R1 or their daughter have a concern NHA-A talks to staff about it.On 9/8/25, at 8:08am, Surveyor interviewed NHA-A and was told a self-report was filed with the state agency. It is being actively investigated, and the investigation is due tomorrow. A copy of the Division of Quality Assurance form F-62617 was provided. Surveyor noted that the email notification indicated being sent on 8/31/25, at 7:41pm. The self report form F-62617, documented the date that the incident was discovered as 9/2/25. Surveyor noted that NHA-A had previously being informed of the incident on August 31, 2025 via email, but the facility did not report the incident then to the state agency. On 9/8/25, at 9:34am, Surveyor followed up with NHA-A regarding the process when an allegation comes in over a weekend or Holiday. NHA-A stated a normal allegation would be reported to the nurse who then notifies the nurse manager. The nurse manager then reports concerns to the NHA-A. Surveyor asked if an email was sent on 8/31/25, why the delay in reporting until 9/2/25. NHA-A responded that they did not receive the email until Tuesday due to the holiday and that is when they responded and filed the self report. Surveyor asked if anyone else scans emails for time sensitive emails and

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R2) of 4 residents reviewed for quality of care received treatment and care in accordance with professional standards of practice. * R2 developed a rash and R2's physician was not notified in order for R2 to obtain treatment. Findings include: The facility policy and procedure titled, Standard Skin Protocol, with no date, documents, in part: Goal: Breaks in skin integrity will be minimized with current plan of care.RN: Complete skin assessment on admission, weekly with bath and PRN (as needed).Consult wound certified Nurse PRN.Individual/POA (power of attorney) education regarding minimizing skin breakdown.Notify MD (medical doctor) of changes in skin integrity as nurse observations deem appropriate.R2 was admitted to the facility on [DATE] with pertinent diagnoses that include hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side (a serious neurological condition characterized by paralysis (hemiplegia) or weakness (hemiparesis) on the left side of the body, with the left hemisphere of the brain being dominant), polyneuropathy (the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged. This condition often causes weakness, numbness and pain, usually in the hands and feet), morbid obesity (a condition in which you have a body mass index (BMI) higher than 35. BMI is used to estimate body fat and can help determine if you are at a healthy body weight for your size), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months).R2's Quarterly Minimum Data Set (MDS) with an assessment reference date of 8/8/25, documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R2 is cognitively intact. The MDS documents that R2 was assessed to have no behaviors exhibited during the look back period. R2's Patient Health Questionnaire (PHQ-9) score was 00, indicating no depressive symptoms. R2 is coded as making self understood and understands others. Per the MDS, R2 has an impairment on one side for both the upper and lower extremities. The MDS indicates R2 is frequently incontinent of bladder and always incontinent of bowel.R2's care plan documents the resident has potential for pressure ulcer development r/t (related to) Immobility, incontinence, PVD (peripheral vascular disease) that was initiated on 08/07/2023, and revised on 10/31/2024, with the following interventions: Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Revision on: 06/13/2025 Inform the resident/family/caregivers of any new area of skin breakdown. Date Initiated: 08/07/2023 Staff to assist with routine toileting and skincare for incontinence. Date Initiated: 08/07/2023 Staff to assist with turning and repositioning. Uses air mattress with bolster. Date Initiated: 08/07/2023\Surveyor was unable to locate additional skin care plans not related to pressure ulcers.R2's physician order dated 6/15/23 documents: complete weekly skin check and bath Thursday PM shift. Note whether resident takes a tub bath (T), bed bath (B), or a shower (S) every evening shift every Thu (Thursday) Complete Skin Only Evaluation. Document bath refusals. Weight. R2's Skin Only Evaluation dated 7/24/25, under Skin section documents Does Resident have current skin issues? is marked as Yes. The Skin Issue selected is Rash. Location is documented as abdominal folds/breast folds. Skin Note is documented as resident has moderate redness to folds. Provider Notification is left blank. Education Provided questions are each marked no.R2's late entry nurse's note created on 9/8/25, with an effective date of 7/24/25, documents Resident had a mild rash in abdominal folds-she was cleaned and dried well with barrier cream applied.On 9/4/25, at 2:02pm, Surveyor interviewed Nurse Supervisor-O regarding when Skin Only Evaluations should be done and was told they should be done on bath days. They were just put in by the Director of Nursing (DON) to be done weekly. Surveyor showed the 7/24/25 Skin Only Evaluation to Nurse Supervisor-O and asked why notification to the physician was not done. Nurse Supervisor-O wanted to look into this.On 9/4/25, at 2:25pm, Nurse Supervisor-O followed up with Surveyor and stated they did not know about the rash on 7/24/25 and does not know why the physician wasn't notified.On 9/8/25, at 8:34am, Surveyor interviewed DON-B regarding the Skin Only Assessment completed on 7/24/25 indicating R2 had a rash and the physician was not updated. DON-B stated she would look into it.On 9/8/25, at 9:31am, DON-B followed up with Surveyor that they talked to the nurse who charted the rash on 7/24/25 and they stated it was mild redness that they cleaned and put barrier cream on. Surveyor asked what the expectation would be for contacting the physician with skin concerns. DON-B stated that for mild redness they would not expect the nurse to contact the physician. DON-B stated the nurse put in a late entry progress note about the redness Surveyor noted

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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 observation, interview, and record review, the facility did not ensure 2 (R1 & R3) of 3 residents received adequate supervision and assistance devices to prevent accidents.*R1 was admitted to the facility on [DATE] with a history of falls. R1 fell on 8/11/25 while attempting to self transfer. The facility did not thoroughly investigate this fall and was aware of R1's multiple attempts to self transfer but did not address R1's self transferring behaviors. On 8/19/25 R1 fell, was transferred to the hospital and diagnosed with a pelvic fracture. R1 returned to the facility on 8/28/25. On 8/31/25 R1 fell. The facility did not thoroughly investigate this fall.*R3's falls on 6/26/25, 7/7/25, 7/13/25, 7/29/25, 8/2/25, 8/20/25, & 8/26/25 were not thoroughly investigated. On 9/4/25 R3 received the incorrect diet for lunch., putting R3 at risk for choking. On 9/8/25 during morning cares, R3 bed was not lowered according to R3's falls plan of care when CNA-L went into the bathroom and/or left R3's room.Findings include:The facility's policy titled, Falls and last reviewed 5/8/25 documents under Policy Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls. Under Procedure documents .2. Procedure of Fall Event and Implementation of Intervention: a. Licensed nurse completes electronic documentation of the Fall Incident Report. b. The care plan will be updated with an identified intervention. c. Registered Nurse reviews and completes the fall assessment and interventions. d. Fall follow-up assessments completed as indicated. 3. Administrative Review: a. The Interdisciplinary Team (IDT) will review Fall Incident report and utilize root cause analysis to make further recommendations. b. Director of Nursing (or designee) and Executive Director to review and sign Fall Incident Report. c. Quality Assurance and Process Improvement Committee reviews facility fall incidents and trends.On 9/4/25, at 12:01 p.m., Surveyor asked Registered Nurse (RN)-G to explain the process when a resident has a fall. RN-G informed Surveyor that after a fall, an RN will assess the resident from head to toe, obtains vital signs, contact the provider and POA if the resident has one have one. RN-G indicated an incident report, pain assessment, progress note, and fall assessment are completed. RN-G informed Surveyor usually the unit manager will let them know what new fall intervention was initiated. RN-G informed Surveyor if the fall was witnessed she will get witness statements and give these to the manager. If the fall is unwitnessed she will usually ask the CNAs questions such as who last saw the resident, if their bed was in a low position. RN-G informed Surveyor that the statements are then given to the unit manager.On 9/4/25, at 2:12 p.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-I to explain the process when a resident falls. LPN/UM-I informed Surveyor when a resident falls staff will let her know and if she is at the facility she will put in a new fall intervention. If she is not at the facility when she will comes back she will put in an intervention. LN/UM-I explained all assessment have been completed, she will do an investigation, the IDT (interdisciplinary team) will do a root cause and an intervention. Surveyor asked if LPN/UM-I if during the investigation she gets staff statements or are staff interviewed. LPN/UM-I informed Surveyor the nurse usually gets statements and puts them under her door. Surveyor asked what happens with staff statements. LPN/UM-I informed Surveyor they would be with the packet that is given to DON-B. Surveyor asked LPN/UM-I what she provides to DON-B. LPN/UM-I informed Surveyor the the investigation summary which includes what happened, diagnoses, IDT met discussed incident with root cause and care plan intervention. All assessments are printed out which include risk management, nurses note, fall risk assessment, pain assessment, and e-interact change of condition which is like an SBAR, and copy of the care plan with interventions. LPN/UM-I informed Surveyor she will put a new Kardex in the resident's room with the new intervention. Surveyor asked LPN/UM-I if DON-B would have staff statements. LPN/UM-I replied yes if there were statements given to me.1.) R1 was originally admitted to the facility on [DATE] with diagnoses which includes cardiogenic shock (inadequate blood flow to the body's organs due to dysfunction of the heart), diabetes mellitus (high blood sugar), atrial fibrillation (irregular and rapid heart beat), atrial fibrillation (irregular and rapid heartbeat), chronic kidney disease (kidneys are damaged and cannot filter blood and waste effectively), and heart failure (chronic condition in which the heart doesn't pump blood as well as it should). R1's hospital Discharge summary dated [DATE] for reason for hospitalization is falls.R1's fall risk evaluation dated 7/25/25 has a score of 4. A total score of 10 or greater is high risk for falls.R1's at risk for falls care plan initiated 7/25/25 & revised 8/31/25 documents the following interventions: Anticipate and meet the resident's needs, initiated 7/25/25. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for