STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525421	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on observation, interview, and record review, the facility failed to provide quality care in accordance with physician orders for one of four sample residents (Resident (R) 2). Specifically, the facility failed to perform a post void residual on R2 every shift as ordered. Findings include: Review of the Admission Record, found in the Electronic Medical Record (EMR) under the Profile tab, documented R2 was admitted to the facility on [DATE] with diagnoses of benign prostatic hyperplasia (BPH) (prostate gland enlargement that can cause urination difficulty) without lower urinary tract. Review of the Admit/Readmit Screener form, found in the EMR under the Assessment tab, dated 05/10/24, documented R4 was alert and oriented, required limited assist with toilet use, was continent of bowel and bladder functions, and had no increased frequency, or difficulty initiating flow. Review of the Physician Orders, dated 05/11/24, documented tamsulosin and finasteride for BPH. Review of the Nurse's Note, dated 05/13/24, documented R2 complained of urinary urgency, a Post Void Residual (PVR, measures the amount of urine left in your bladder after you urinate) was completed and R2 had 1 milliliter (ml) in his bladder after urination. Review of the admission Minimum Data Set (MDS) found in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 05/17/24, documented R2 had a Brief Interview of Mental Status (BIMS) score of 15 that indicated intact cognition, was continent of bowel and bladder function, and required supervision with transfer activities, toileting, and ambulation. Review of the 05/14/24-05/22/24 Nurse's Notes found in the EMR under the Progress Note tab revealed R2 had intermittent urinary urgency, a urine sample was negative for a urinary tract infection, and R2 was started on UTI stat (medical food provided for the dietary management of UTIs and urinary tract health) on 05/17/24. Review of the Physician Orders found in the EMR under the Orders tab, dated 05/22/24 documented, Obtain a post void residual (PVR) every shift. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment Administration Record (TAR) found in the EMR under the Order tab dated 05/22/24 to 05/28/24 did not document PVRs for R2. Review of the complete EMR did not document any additional PVRs completed on R2 other than the PVR documented on 05/13/24. Interview on 08/28/24 at 3:54 PM, Registered Nurse (RN) 1 said R2 was alert and oriented, and continent of urine. She said R2 used the bathroom and/or urinal. RN1 said R2 occasionally complained of urinary frequency and never complained of abdominal pain. RN1 said she did not recall R2 having an order for PVRs, and she did not complete PVRs on R2 every shift. She said PVRs would be recorded in the TAR. Interview on 08/29/24 at 5:15 PM the Director of Nurses (DON) said there was only one PVR documented in R2's nurse's notes and she was not able to locate any other PVRs for R2. The DON said the physician order was not transcribed in the TAR and therefore, the nurses did not obtain PVRs on R2 as ordered by the Nurse Practitioner (NP). Interview on 08/02/24 at 10:00 AM, the NP said R2 complained of urinary frequency and not being able to completely empty his bladder. She said she was not aware that the PVRs on R2 had not been completed every shift as ordered. The NP said the expectation was that R2's PVRs would be completed every shift, and she would be notified if there were issues completing the PVR, such as the resident's refusal or the results of the PVRs were abnormal.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15013 Based on record review, interview, and policy review, the facility failed to follow the facility's pain policy to ensure effective pain management for one of four residents (Resident (R) 4), reviewed for pain out of a total sample of four residents. This failure resulted in harm when R4 had increased pain and cried and screamed for 3.5 hours awaiting administration of her narcotic pain medication Findings include: Review of the policy titled, Pain, dated 08/10/23 provided by the Director of Nurses (DON) documented, The Pain Tool shall be completed upon admission and quarterly. The Pain Tool shall be completed upon change in condition or if indicated. Staff will manage an individual-centered interdisciplinary care plan and implement interventions/approaches to pain management including non-pharmacological interventions .The medical provider will be consulted if pain interventions are not effective . Review of the policy titled, Medication Orders Controlled Substance Prescriptions, dated May 2018 provided by the DON, documented: under procedures: Full name and address of the resident, including street address of the facility .The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not, or will not be available . Review of the Admission Record found in the Electronic Medical Record (EMR) documented R4 was admitted to the facility on [DATE] with diagnoses of restless leg syndrome and arthrodesis status (orthopedic surgery in which two or more bones in a joint are fused to become one larger bone). Review of the Pre-Operative History and Physical report, dated 08/08/24, documented that R4 had lumbar adjacent segment disease with spondylolisthesis and was to have decompression surgery of the lower back to include fixation and fusion of the vertebrae of the low back. Review of the Admit/Readmit Screener form found in the EMR under the Assessment tab dated 08/13/24 at 10:47 PM revealed R4 had intact cognition, rated the pain in her back at a 10, which was the highest level of pain. The pain was described as varied, achy, and severe, started after her back surgery, was worsened with movement, and relieved with Oxycodone. Review of the Interim Care Plan found in the EMR under the Assessment tab, dated 08/13/24, revealed R4 had mid to lower back related to incisional pain. The date of the most recent pain level or pain scale as listed on the form was blank. Review of the Physician Orders found in the EMR under the Orders tab, dated 08/13/24, documented the following orders for R4: Oxycodone (the narcotic pain medication) 5 milligrams (mg)-give one tablet every four hours as needed (prn) for pain for seven days, Oxycodone 5mg-give two tablets every four hours prn for pain for seven days, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lidocaine Patch 5% topically once a day for pain until 09/12/24, may wear two patches up to 12 hours, must have 12 hours patch free, gabapentin 300 mg- give three times per day for nerve pain, Methocarbamol (muscle relaxant) 500 mg- give every six hours prn for pain until 08/27/24 and Tylenol PM Extra Strength 500/25 mg (diphenhydramine-acetaminophen)- give two tablets every 24 hours prn for insomnia at night. Review of the Weights/Vital Signs report found in the EMR under the Weights/Vital Signs tab, dated 08/13/24, revealed R4 had a pain rating of zero at 10:47 PM and seven at 10:58 PM. Review of the Nurse's Note found in the EMR under the Progress Note tab, dated 08/14/24 at 12:14 AM, documented R4 was alert, able to make her needs known, complained of severe pain in her back, and was given two Oxycodone (10 mg) at 11:00 PM for pain. Review of the Weights/Vital Signs report found in the EMR under the Weights/Vital Signs tab, dated 08/14/24, revealed R4 had a pain rating of zero at 12:34 AM. Interview on 08/27/24 at 4:05 PM, R4 said when she was admitted to the facility around 3:00 PM on 08/13/24, she had moderate pain and received Tylenol. She said the Nurse told her she would give her Oxycodone when available. R4 said at approximately 6:00 PM, her pain level was a ten and was the worst pain she had experienced. R4 said the nurse told her she would contact the Pharmacy to access the Oxycodone. R4 said she yelled out in pain for approximately 3 1/2 hours before she received Oxycodone. She said her husband offered to bring her Oxycodone from home and left about 9:00 PM. She said her home was approximately 45 minutes each way. R4 said the staff checked on her frequently and asked what they could do to help her, and she told them she just needed pain medication. R4 said she dosed off for a very short time and when she awakened, she was given Oxycodone. She said although the medication did not take away the pain, the pain was more tolerable. She said she continued to receive Oxycodone every four hours. R4 said after receiving the Oxycodone for a day, her pain level was in good control. Interview on 08/29/24 at 11:23 AM, Licensed Practical Nurse (LPN) 3 said on 08/13/24, she worked the 2:00 PM to 10:00 PM shift. She said R4 was admitted to the facility between 3:00 PM and 4:00 PM on 08/13/24 and was alert and oriented, was able to step off the stretcher and was assisted to her bed with the emergency medical technicians (EMTs) and was not crying in pain. She said R4 had moderate pain, which she would have rated at a seven. LPN3 said she told R4 they had an order for Oxycodone for her pain, which they kept locked at the facility, and she would call the pharmacy to obtain the code to get the Oxycodone. She said she told R4 she could give her Tylenol and would give her Oxycodone as soon as possible. R4 said that was fine. LPN3 went on to say the hospital had sent a hard copy for R4's Oxycodone to the pharmacy LPN3 said she called the pharmacy between 5:30 PM and 6:00 PM to obtain the code to unlock the Oxycodone. She said the person at the pharmacy told her the Pharmacist would call her back in two to four hours. LPN3 said she told the pharmacy person R4 was in excruciating pain and was crying and she needed to obtain Oxycodone for R4 immediately. She gave the person her personal cell number to ensure she would receive the call. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN3 said she informed R4 the pharmacy was called, and she was awaiting a call back. LPN3 said R4's pain rating increased to a 10 at approximately 6:00 PM. She said she offered R4 more Tylenol and R4 declined. LPN3 said R4 said she had Oxycodone at home and her husband said he would go home and get the medication, which would take him about one hour and 45 minutes. She said she told the husband if the medication was the same, they could give R4 that medication until the Oxycodone was available at the facility. LPN3 said she did not notify the on-call Nurse Practitioner (NP), notify the Director of Nurses (DON), or consult a nurse on another unit regarding R4's pain and need for Oxycodone, as they could not get the Oxycodone from the Omnicell until the pharmacist called back with the code. LPN3 said she did not offer ice or repositioning as R4 said she just wanted pain medication. LPN3 said she had a meeting with the DON and Human Resource person that evening at approximately 10:00 PM. She said when she left for the meeting, R4 still had a pain rating of ten and was crying. She said at the end of the meeting, at approximately 10:40 PM, she informed the DON of the issue with R4's Oxycodone. LPN3 said on route to R4's room, a CNA told her the pharmacy was on the telephone. LPN3 said she obtained the verification code and took eight Oxycodone out of the Omnicell and informed the DON. LPN3 said the night nurse told her R4 was sleeping. LPN3 said she told the oncoming night nurse that R4 had severe pain and cried for 3 1/2 hours while waiting for the Oxycodone. During an interview on 08/29/24 at 2:28 PM, Certified Nursing Assistant (CNA) 2 stated during the evening shift on 08/13/24, she observed R4 screaming in pain being transported via a stretcher to her unit between 2:30 PM-3:00 PM. CNA2 stated she had no additional observations of R4 on that evening. On 08/29/24 at 2:26 PM, a message was left for the CNA3, who was assigned to R4 during the evening shift of her admission Interview on 08/30/24 at 12:10 PM, the Pharmacy Facility Manager said the cut off time for nurses to input new orders for new admissions into the computer system to obtain medications during the evening run (usually between 11:00 PM and 1:00 AM) is 7:00 PM. He said a code is required from the Pharmacy to obtain narcotic medications from the Omnicell. The Pharmacy Facility Manager said on 08/13/24, at 2:47 PM, the pharmacy had a hard copy from the hospital for Oxycodone for R4. The script did not contain information as to where R4 resided. He said the Oxycodone was flagged and a code was ready to be given as soon as the facility contacted the pharmacy or emergency pharmacy and gave the facility address as to R4's location. The Pharmacy Facility Manager said the pharmacy closes at 7:00 PM and the on-call pharmacy is available from 7:00 PM to 8:00 AM the following day. He said the on-call pharmacy would not be able to give a code to the facility nurse until they called and gave R4's location. The Pharmacy Facility Manager said on 08/13/24, the facility inputted the nonnarcotic medications into the computer at 8:21 PM, which placed R4 on file in the system with the facility location. He said the on-call pharmacy had access to that information. The Pharmacy Facility Manager said if the nurse needed Oxycodone for R4 and it was after 7:00 PM, she would have to call the on-call pharmacy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacy Facility Manager said per the on-call pharmacy telephone notes, the nurse at the facility called the on-call pharmacy at 8:14 PM. The person at the pharmacy notified the pharmacist or pharmacy technician, who located the resident information, and that Oxycodone was needed for R4. He said he had no information regarding anyone telling the nurse the turnaround time would be two to four hours. The Pharmacy Facility Manager said the transcript from pharmacy documented that the on-call pharmacy called both numbers listed for the facility at 8:39 PM and 9:21 PM and left a message to call the on-call pharmacy back. He said the transcript documented that at 9:59 PM, the pharmacist called and got a voice mail and answering machine. The Pharmacy Facility Manager said on 08/13/24 at 10:36 PM the Pharmacist spoke to a nurse at the facility and gave the code to obtain Oxycodone from the Omnicell. Review of the Nurse's Note found in the EMR under the Progress Note tab, dated 08/13/24 at 11:49 PM documented R4 arrived at the facility at 3:53 PM accompanied by her spouse. R4 was given Tylenol for a pain scale of seven (moderate pain) upon arrival. The writer called the pharmacy to get an authorization to give Oxycodone to R4 as she was up and crying in pain for three- and one-half hours. Authorization just came through. Eight pills were pulled. R4 is currently sleeping so pain medication was not given. Gave a report to oncoming nurse that R4 is able to receive pain medication every four hours per the physician order. Although a message was left for the above nurse, the nurse did not return the Surveyor's call. Interview on 08/29/24, at 3:11 PM, LPN1 said she was assigned to R4's unit during the night shift and was told R4 had a pain rating of 10 during the evening shift and had not been given Oxycodone. LPN1 said after report, at approximately 10:40 PM, she observed R4, who was sleeping and appeared to have no pain. She said just before 11:00 PM, R4 awakened and had a pain rating of seven or eight. LPN1 said she immediately gave R4 Oxycodone 10 mg with good pain relief. LPN1 said R4 received Oxycodone 10 mg at 3:00 AM for a pain rating of eight. LPN1 said R4 slept after receiving the Oxycodone. Interview on 08/29/24 at 3:26 PM, LPN2, said R4 was alert and oriented. She said in the report the night shift nurse told her R4 had severe pain and had to wait for her pain medication. LPN2 said shortly after shift report, R4 had pain rating of ten, was given Oxycodone with effect. LPN2 said R4 told her she also took a muscle relaxant, which she had not received. LPN2 said she immediately notified the Pharmacy and told them to deliver the stat [immediately] muscle relaxant, which arrived within an hour at the facility. LPN2 said she notified the Nurse Practitioner (NP) about the Oxycodone. She said the NP discontinued the prn Oxycodone and gave an order for scheduled Oxycodone. During an interview on 08/29/24 at 10:00 AM, the Nurse Practitioner (NP) said the staff are to notify the on-call NP for resident changes in status and resident concerns. She said if the NP were called, the NP could have intervened with the pharmacist to determine why the facility did not have the code to obtain the Oxycodone from the Omnicell. She said another nonnarcotic pain medication could have been ordered and delivered stat to the facility. The NP said a wait time of two to four hours to get a code from the pharmacy to obtain narcotic pain medication was not acceptable. The NP said residents were expected to receive prompt and effective pain management. She said she was not aware until the next day that R4 had severe pain and had a delay in receiving the Oxycodone, the muscle relaxant had not arrived at the facility during the evening delivery of medications and should have been ordered stat from the pharmacy as soon as R4 had pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24 at 1:00 PM the DON said she initiated an investigation into the late Oxycodone on 08/14/24. She said the evening nurse did not notify the Pharmacy timely regarding the need for a code to access the Oxycodone from the Omnicell. The DON said when the pharmacy told the nurse the wait would be two to four hours before a pharmacist called her back, she did not notify her, another nurse in the facility, or the on-call NP. The DON confirmed R4 did not receive effective pain medication for several hours at the facility