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	07/15/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide the opportunity for 1 (R3) of 3 Residents reviewed to participate in the development and implementation of their person-centered plan of care by not facilitating the inclusion of R3 and/or their representative in the care planning process. *R3 was admitted to the facility on [DATE] for short term rehabilitation, and there is no documentation in R3's electronic medical record (EMR) that R3 and/or their representative participated in the development and implementation of R3's person-centered plan of care on a quarterly basis.Findings Include:The facility's Individual Care Plan Conferences policy and procedure last reviewed 3/8/23 documents: . I. Policy: A written Care Plan is developed and maintained directing a course of comprehensive care specific to the individual's needs from all appropriate disciplines and the individual's primary care provider.II. Procedure:A. Evaluations and Updates.1.The care of each individual shall be reviewed by each of the services involved in the individual's care and the care plan evaluated and updated as needed.B. Implementation.1. Baseline Care Plan Summary will be completed within 48 hours of admission and discussed and provided within a week.2. The individual, guardian and/or individual representative will meet with the Interdisciplinary team within 1-2 weeks of admission at an Initial Care Plan Conference.3. An individual care plan review will be held every 3 months after the initial Care Plan Conference is held. Scheduling will be done by the Minimum Data Set (MDS) Nurse or Designee. The Life Coach will invite the individual or responsible party to the Care Plan review.4. The individual, guardian, and their individual representative are invited and informed of changes in treatments and goal of all disciplines.5. Individual care plans are reviewed upon re-admission, change of condition from the hospital, and scheduled into the review schedule.6. The Life Coach reviews the discharge plan on a quarterly basis or as indicated by the individual status.7. The interdisciplinary team reviews with the individual and/or individual representative at the Care Plan Conference identified problems, approaches, and goals.R3 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Hyperlipidemia (high levels of fat particles in blood), Dysphagia (difficulty swallowing foods), Parkinson's Disease (disorder of the central nervous system that affects movement, often including tremors), Essential Hypertension (chronic condition of persistently high blood pressure), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), Bipolar (episodes of mood swings ranging from depressive lows to manic highs), Delusional Disorder (delusions are a specific symptom of psychosis related to thought disorder or mood disorder), and Schizoaffective (combination of schizophrenia and mood disorder symptoms including hallucinations and delusions and manic/depressive episodes). R3 is currently his own person. R3's Quarterly Minimum Data Set (MDS) assessment completed 6/10/25 documents R3's Brief Interview for Mental Status (BIMS) score of 13, indicating R3 is cognitively intact for daily decision making. R3's MDS documents R3 has no mood or behavior symptoms; has range of motion impairment on one side on both upper and lower extremities; uses a wheelchair and walker for locomotion; requires set-up for eating; requires supervision for upper dressing and substantial/maximum assistance for lower dressing; requires partial/moderate assistance for mobility and transfers; and is frequently incontinent of bladder and always continent of bowel.On 7/14/25, at 11:46 AM, Surveyor reviewed R3's EMR and notes R3 has only one documented care conference dated 12/5/24. Surveyor notes based on a quarterly basis, R3 should have had a care conference 3/25 and 6/25.On 7/14/25, at 1:34 PM, Surveyor interviewed Life Coach (LC)-C in regard to R3's care conferences. LC-C informs surveyor she is aware care conferences should be held with the Resident and/or representative to discuss the Resident's plan of care. LC-C is not sure why there is only one documented care conference for R3 and will look for further documentation.On 7/14/25, at 2:30 PM, LC-C provided documentation of a care conference held with R3 and R3's representative on 12/5/24, two days after admission. LC-C has no documentation of any other care conferences held for R3. LC-C confirmed R3 has not been offered the opportunity to have a care conference in order to review R3's person-centered plan of care. LC-C was not aware that care conferences for Residents should be completed on a consistent basis or as needed in order to review R3's person-centered plan of care and update with new or revised interventions. LC-C informed Surveyor that LC-C will schedule a care conference for R3.On 7/14/25, at 3:33 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 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 (R1) of 3 residents reviewed received a prompt resolution of grievances filed, including documentation of steps taken to investigate the grievance, and corrective actions taken by the facility as a result of the grievance.R1's POA filed three grievances with the facility, and there is no evidence of the grievances being thoroughly investigated or a resolution obtained and shared with the complainant. Findings include: The facility policy and procedure entitled Grievance dated 5-8-91 with review date of 2-21-2024 documents:. Policy: individual, guardian, and/or individual representative will be informed of the process to file a grievance or complaint and the facility's process to make prompt efforts to resolve grievances.Procedure: The facility fosters and environment of direct communication, prompt resolution, and continuous process improvement.B. Formal Grievance:1. All staff has access to the formal Grievance Form. Formal Grievance is to be submitted to the Grievance Officer upon completion.2. Grievance Officer will log all formal complaints onto the Grievance Tracking Log. Grievance Officer will provide a Quality Assurance designee with the written Grievance Form and keep a copy. Quality Assurance designee will assign a manager to complete the Quality Assurance Grievance investigation.3. The assigned manager will investigate the grievance and respond to the individual, guardian, and/or individual representative within five (5) working days, unless further investigation is needed.R1 was admitted to the facility on [DATE], with diagnoses that include hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, vascular dementia, anxiety, and type 2 diabetes mellitus.R1's most recent Quarterly Minimum Data Set (MDS) assessment completed 4/29/25 documents R1 is frequently incontinent of bladder and bowel, and R1 requires partial assistance for showers, dressing, bed mobility, transfers, and to walk ten feet. R1 has a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. R1 has an activated healthcare power of attorney (POA). On 7/14/25, at 9:51 am, Surveyor spoke with R1's Power of Attorney (POA)-O via phone call. POA-O stated Life Coach (LC)-C would not help POA-O with renewing R1's Medicaid after POA-O asked LC-C for assistance with the process. POA-O stated this issue has not been resolved.Surveyor reviewed the facility's grievance logs for February to July 2025 and identified three grievances listed for R1. Review of the three Grievance Investigation forms identified LC-C as the assigned investigating individual and the Grievance Officer reviewing resolution.Surveyor reviewed grievance dated 7/2/25 completed by LC-C, which documents POA-O asked for assistance completing Medicaid renewal for R1 and POA-O became upset when LC-C explained LC-C cannot complete renewal. LC-C documented in the grievance investigation that the Medicaid renewal process was discussed with POA-O and R1's granddaughter previously, but POA-O did not want to use R1's granddaughter's assistance completing the Medicaid renewal process. LC-C documented the resolution for the grievance as LC-C will assist with answering questions about the application, but due to POA-O's behavior additional person will be present. No documentation was noted of arranging an appointment with POA-O or having a different staff member assist POA-O with R1's Medicaid renewal application.On 7/14/25, at 1:35pm, Surveyor interviewed LC-C regarding LC-C's role assisting residents with Medicaid applications and renewals. LC-C stated residents and families can work with LC-C to complete the Medicaid application, and LC-C has helped families complete a paper application or a computer application in the past. Surveyor asked LC-C why POA-O was not assisted with completing R1's Medicaid renewal. LC-C replied LC-C offered answering POA-O's questions about the Medicaid application but told POA-O that LC-C was not able to complete the application and was only a supporting role. LC-C stated POA-O has not requested an appointment with LC-C to go over the Medicaid application, and LC-C has not scheduled a meeting due to POA-O having a history of not showing up to previous appointments. LC-C did not offer further information as to why no other attempts were made by LC-C or another designated staff member to assist POA-O with filling out R1's Medicaid application promptly.A nursing progress note dated 6/27/25, documented R1's dentures were reported missing to Registered Nurse (RN)-N and were not able to be located. A grievance was not filed by LC-C until 7/3/25. Upon review of the grievance dated 7/3/25, no staff interviews were completed indicating when R1's dentures were last seen.A nursing progress note dated 7/5/25, documents R1's POA was upset the dentures were missing and the POA was not made aware.On 7/15/25, at 9:47 am, Surveyor interviewed Food Service Director (FSD)-L who stated on 7/5/25, R1's POA approached FSD-L upset that R1's dentures were missing. FSD-L provided Surveyor an email printout dated

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R1) of 3 residents' care plans reviewed were revised as needed based on preferences and needs of the resident.R1's care plan was not revised to include interventions for the safe storage of R1's dentures.Findings include:On 7/14/25, at 9:51 am, Surveyor spoke with R1's Power of Attorney (POA)-O via phone call. POA-O stated the facility lost R1's dentures.The facility policy titled Comprehensive Person-Centered Care Plan with implementation date of 7/9/19 and reviewed date of 5/8/25, documents:.Policy: the Comprehensive Person-Centered Care Plan will reflect the individual's needs and preferences to facilitate care.Procedure:A. Within 48 hours after admission: a Baseline Care Plan will be completed and reviewed with Individual and/or Individual Representative.B. Within 21 consecutive days after admission, and in correlation with the Minimal Data Set (MDS), a comprehensive assessment will be completed and a written care plan will be developed based on the individual's history, preferences, and assessments.C. Care Plan shall be reviewed and revised quarterly, upon change of condition, and/or as neededD. Individual and/or Individual Representative and direct care staff will participate in development of the comprehensive person-centered care plan.R1 was admitted to the facility on [DATE], with diagnoses that include hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, vascular dementia, and anxiety.R1's most recent Quarterly Minimum Data Assessment (MDS) assessment completed 4/29/25 documents R1 requires partial assistance for activities of daily living (ADLs) and has dentures. R1 has a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. R1 has an activated healthcare power of attorney (POA). R1's care plan documents R1 has an activity of daily living (ADL) performance deficit with the following interventions initiated on 12/19/2024:-remind [R1] to put on dentures every morning-remind [R1] to take out dentures at nightNursing progress note dated 6/27/25, written by Registered Nurse (RN)-N documents: was notified R1's dentures were missing and R1 removed dentures earlier in the day and placed them in a bag with R1's toothbrush. The facility was later able to locate R1's dentures. Nursing progress note dated 7/5/25, documents R1's dentures were reported missing again. The facility was not able to locate R1's dentures.On 7/15/25, at 9:54 am, Surveyor interviewed Certified Nursing Assistant (CNA)-M regarding typical denture management for residents. CNA-M stated dentures can stay in the resident's bathroom or can be kept in the medication cart upon resident or resident's family request. CNA-M stated R1's dentures are kept in R1's bathroom.On 7/15/25, at 12:53 pm, Surveyor shared concerns with NHA-A and DON-B that R1's care plan was not revised to include interventions of how to store R1's dentures overnight, including if they should be kept in R1's room or locked up in the medication cart. No further information was provided to Surveyor.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 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 observation, interview, and record review, the facility did not ensure 1 (R1) of 3 residents reviewed received the appropriate treatment and services to maintain the ability to carry out activities of daily living, including mobility and elimination.R1 was not provided assistance walking in hallways or to the bathroom, was not transferred at the highest practicable level, and was not provided toileting care as indicated in R1's care card and care plan.Findings Include:The facility policy titled Safe Individual Handling Program, with implementation date of 2/8/17 and reviewed date of 5/8/25 documents: . Procedure: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.R1 was admitted to the facility on [DATE], with diagnoses that include hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, vascular dementia, anxiety, chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, chronic kidney disease, and type 2 diabetes mellitus.R1's admission Minimum Data Set (MDS) assessment completed 1/23/24 documented R1 was frequently incontinent of bladder and occasionally incontinent of bowel, and R1 required partial assistance for showers and upper body dressing, maximal assistance for lower body dressing, partial assistance for bed mobility and transfers, and R1 was unable to ambulate.R1's most recent Quarterly MDS assessment completed 4/29/25 documents R1 is frequently incontinent of bladder and bowel, and R1 requires partial assistance for showers, dressing, bed mobility, transfers, and to walk ten feet. R1 has a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. R1 has an activated healthcare power of attorney (POA). Surveyor reviewed R1's care plan which documents R1 has an activities of daily living (ADL) self-care performance deficit, with the following interventions initiated 1/17/24: .-encourage the resident to participate to the fullest extent possible with each interaction.Surveyor reviewed R1's care card dated 7/14/25 which documents R1's transfer status as assist of one with 2-wheeled walker and gait belt, to ambulate with R1 to/from the bathroom with assist of one with gait belt and 2-wheeled walker, R1 may ambulate in the hallways with staff with wheeled walker with assist of one and walk with R1 each day in the hallways to maintain [R1's] strength. On 7/14/25, at 1:15pm, Surveyor interviewed Certified Nursing Assistant (CNA)-D regarding R1's transfer and mobility status. CNA-D responded CNA-D did not know R1 was able to walk and has never walked with R1. CNA-D stated R1 usually transferred with a Sara Steady (manual sit-to-stand) lift. Surveyor asked CNA-D how a resident's transfer status would be determined and CNA-D replied it would be found in the resident's care card or therapy would tell staff.On 7/14/25, at 2:32 pm, Surveyor interviewed Certified Occupational Therapy Assistant (COTA)-G regarding how resident transfer status is communicated to staff. COTA-G stated therapy staff lets CNA staff know if someone can walk to the bathroom, but was not clear how it was put into the computer system.On 7/14/25, at 2:53 pm, Surveyor interviewed Physical Therapist (PT)-H and Director of Rehab (DOR)-I on how transfer status is determined for residents. PT-H stated PT or Occupational Therapist (OT) will make an assessment and put the transfer status on the Kardex (care card). PT-H stated the care card for R1documented assist of one for transfers and stated the expectation was for CNA staff to walk with R1 daily.On 7/15/25, at 9:54 am, Surveyor interviewed CNA-M regarding R1's transfer and mobility status. CNA-M stated R1 needs the Sara Steady lift and R1 only walks with therapy.On 7/15/25, at 10:41 am, Surveyor interviewed Nurse Supervisor (NS)-E regarding how a resident's transfer status is determined. NS-E stated the resident's baseline transfer status would be based on hospital paperwork, then therapy or nursing would update the care card or therapy would email NS-E with updated recommendations. NS-E stated aides would look on the care card to see how a resident transfers. NS-E looked at R1's care card and confirmed it documents CNAs should transfer R1 with assist of one with a walker and gait belt, CNAs should walk with R1 to and from the bathroom with a walker and assist of one, and CNAs should walk with R1 each day in the hallways to maintain strength. NS-E confirmed the care card does not state to use a Sara Steady with R1 for transfers. NS-E stated CNA staff would be able to use a Sara Steady lift with a resident on an as needed basis, but a resident's transfer status would only be changed in the care card by therapy or nursing staff.Surveyor reviewed R1's care plan which documents R1 has bladder incontinence

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. (continued on next page)

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F 0825 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 staff interviews and record review, the facility did not ensure therapy services were provided in a timely manner for 1 (R1) of 1 resident reviewed for therapy services.R1 received orders to start physical therapy (PT) and occupational therapy (OT) dated 4/29/25. PT and OT services were not initiated until 7/14/25.Findings Include: R1 was admitted to the facility on [DATE], with diagnoses that include hemiplegia and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side, anxiety, chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and type 2 diabetes mellitus.R1's most recent Quarterly Minimum Data Set (MDS) assessment completed 4/29/25 documents R1 requires partial assistance for showers, dressing, bed mobility, transfers, and to walk ten feet. R1 has a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. R1 has an activated healthcare power of attorney (POA). Surveyor requested a policy and procedure for following physician's order and/or a policy for receiving rehabilitation services when ordered. Nursing Home Administrator (NHA)-A stated the facility did not have this policy or procedure.Surveyor reviewed facility OT discharge summary for R1 dated 12/6/24 stating R1 required the following:-minimal assistance for upper body dressing-contact guard assistance to minimal assistance for toilet transfers-moderate assistance for toileting hygiene and clothing management-moderate assistance for sit to stand transfers-contact guard assistance to minimal assistance for pivot transfers-[R1] may ambulate with 2-wheeled walker with staff assist in room and hallway as toleratedSurveyor noted facility OT discharged services for R1 on 12/6/24 due to highest practical level achieved. Surveyor reviewed facility PT discharge for R1 dated 2/3/25 stating R1 required the following:-contact guard assistance to minimal assistance for bed mobility-moderate assistance for sit to stand transfers-contact guard assistance for pivot transfers-able to ambulate with 2-wheeled walker and assist of one personSurveyor noted facility PT discharged services for R1 on 2/3/25 due to plateau in progress.Surveyor reviewed R1's electronic health record (EHR) and noted a new written order scanned into miscellaneous documents from R1's physician dated 4/29/25 to start PT and OT.Surveyor was unable to locate any progress notes in R1's EHR regarding the new therapy orders received on 4/29/25.Surveyor noted in a progress note written by Nursing Home Administrator (NHA)-A dated 7/11/25, R1's POA would like R1 to do therapy, and NHA-A shared this information with the therapy department.On 7/14/25, at 1:10 pm, Surveyor interviewed R1 who stated therapy saw R1 that morning.On 7/14/25, at 2:53 pm, Surveyor interviewed Physical Therapist (PT)-H and Director of Rehab (DOR)-I regarding the process of receiving new therapy orders, and therapy orders for R1. DOR-I replied the therapy department is usually told of any new therapy orders by the in-house nurse practitioner, but R1 has a doctor outside the facility. DOR-I was informed R1's POA wanted therapy for R1 and DOR-I located the PT and OT order dated 4/29/25 in R1's EMR. Then PT and OT performed evaluations on 7/14/25. Surveyor asked PT-H what R1's level of function was upon evaluation. PT-H responded R1 requires maximal assistance for bed mobility, moderate assistance for transfers, and can ambulate 40 feet with contact guard assistance to minimal assistance with a 2-wheeled walker. DOR-I stated the nurse or nurse manager would put any new orders in the HER and that is how therapy would become aware of new orders. Surveyor asked DOR-I why there was a delay in initiating therapy for R1. DOR-I replied DOR-I takes responsibility for not initiating therapy for R1 after receiving the initial written order on 4/29/2025. DOR-I stated DOR-I was not sure what happened, but when NHA-A stated R1 would like to start therapy DOR-I recalled an order and looked in DOR-I's paperwork and found the written order from 4/29/2025.On 7/15/25, at 10:41 am, Surveyor interviewed Nurse Supervisor (NS)-E regarding the process of receiving new therapy orders for a resident. NS-E stated the floor nurse would take notes from a doctor appointment and transcribe any new orders into the resident's EHR in the physician orders tab. NS-E was not able to locate any new orders in the physician orders tab for PT and OT to start on 4/29/25.On 7/14/25 at 3:30 pm, Surveyor shared concern with NHA-A and DON-B about the delay in therapy for R1 that was ordered on 4/29/2025 but not initiated until 7/14/2025. No additional information was provided as to why therapy services were delayed for R1.