

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Menomonee Falls		STREET ADDRESS, CITY, STATE, ZIP CODE W180 N8071 Town Hall Rd Menomonee Falls, WI 53051	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin (IUO) within required timeframes to the State Survey Agency (SSA) for one of three residents (Resident (R) 2) reviewed for abuse out of a total sample of six. Failure to report injuries of unknown origin places all residents at risk of abuse. Findings include: Review of R2's "admission Record," located in the "Profile" tab of the EMR, revealed R2 admitted to the facility on [DATE] with diagnoses including spastic hemiplegia affecting right dominant side and quadriplegia. Review of R2's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/21/25, revealed R2 had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was moderately cognitively impaired. Review of R2's "Nurse's Notes, dated 08/07/25 at 1:57 PM, located in the EMR under the "Notes" tab and written by Licensed Practical Nurse (LPN) 1, revealed, . resident complained of right ankle pain and requested to be sent out to the hospital . Review of R2's "Nurse's Notes," located in the EMR under the "Notes" tab, dated 08/07/25, and written by LPN1, revealed, . resident returned from hospital with order for oxycodone diagnosis closed fracture of the right ankle . Review of the facility's Misconduct Incident Report, submitted to the SSA on 08/12/25 at 12:29 PM and provided by the facility, revealed, . Patient c/o [complain of] sore ankle and wanted to go to the ER [emergency room] patient's POA [Power of Attorney] was called and agreed to have patient sent out to the hospital. Patient was sent out on Thursday 8/7/25 . Patient returned from ER later that evening with closed right ankle fracture. X-ray report reads fracture age undetermined per x-ray report . This report was submitted five days after the IUO was first identified. During an interview on 08/19/25 at 12:02 PM, LPN1 stated after R2 returned from the hospital with a diagnosis for a closed fracture to the right ankle she reported it to the Director of Nursing (DON). During an interview on 08/19/25 at 2:59 PM, the DON stated the fracture was reported to her timely and the Administrator was made aware. The DON stated she believed it was a reportable event, but the Interim Administrator was unsure and wanted to get some additional information. She stated that was why it was reported late.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to thoroughly investigate an injury of unknown origin for one of three residents (Resident (R) 2) reviewed for abuse out of a total sample of six. Failure to thoroughly investigate injuries of unknown origin places residents at risk of continued abuse. Findings include: Review of R2's "admission Record," located in the "Profile" tab of the EMR, revealed R211 admitted to the facility on [DATE] with diagnoses including spastic hemiplegia affecting right dominant side, and quadriplegia. Review of R2's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/21/25, revealed R2 had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated R2 was moderately cognitively impaired. Review of a "Nurse's Note," dated 08/07/25 at 1:57 PM, located in the EMR under the "Notes" tab, and written by Licensed Practical Nurse (LPN) 1, revealed, . resident complained of right ankle pain and requested to be sent out to the hospital . Review of a "Nurse's Note," located in the EMR under the "Notes" tab, written by LPN1, and dated 08/07/25, revealed, . resident returned from hospital with order for oxycodone diagnosis closed fracture of the right ankle . Review of the Self-Report Form, provided by the facility and dated 08/15/25 at 10:69 PM, revealed not all staff involved with R2's care prior to the diagnosis of the closed fracture to the right ankle were interviewed for knowledge related to the incident. Interviews with LPN4 and CNA3 revealed R2 was complaining of ankle pain on 07/06/25 during the second shift, and these staff were not interviewed during the investigation or asked to write a statement. Additional information revealed these staff had direct knowledge of the resident complaining of ankle pain. Further review revealed R2 told staff that her ankle was hurt during a manual transfer by staff when the staff transferred her by themselves without another staff or a Hoyer list. The investigation concluded the most likely cause of the fracture was due to staff improperly transferring the resident during care; however, it could not be verified. During an interview on 08/19/25 at 2:59 PM, the Director of Nursing (DON) stated she was unaware that these staff were not interviewed but agreed that they should have been and their statements should have been included in the investigation.</p>		