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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews, document review, and facility policy review, the facility failed to ensure the timely resolution of grievances raised during monthly Resident Council meetings and failed to document a rationale when grievances were not resolved for repeated concerns with staff attentiveness and call light response times, and housekeeping services for four of seven months of resident council minutes reviewed. This failure placed residents at risk for unmet and delayed care needs, decreased satisfaction with a clean and comfortable living environment, and reduced confidence in the grievance resolution process. Findings include:Review of the facility's policy titled, Grievance last reviewed 03/03/26 revealed, Purpose: 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 an environment of direct communication, prompt resolution, and continuous process improvement.Quality Assurance designee will assign a manager to complete the Quality Assurance Grievance investigation.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.Review of the facility's Resident Council meeting minutes, provided by the facility, dated December 2025 through March 2026, revealed reoccurring grievances with the services provided by the housekeeping department and staff call light response times.Call Light Response:12/16/25 Old Business revealed residents had concerns with staff being on their phones, texting and talking.12/16/25 New Business revealed residents still had concerns with staff using their phones to text and talk at work. It was documented that nursing management was made aware.01/20/26 Old Business restated that residents had concerns with staff using their phones during work.01/20/26 New Business documented that residents reported staff on the third shift were always on their phones and would not answer call lights or do rounds. It was noted that because residents could not specify days and times, they were reminded that if it happened again, the resident should remember date and situation so that investigations with the social worker could be done. Residents again stated concerns with staff using their phone during work. Residents stated that call lights were not answered timely, and that staff often answered the call light and asked what was needed, turned off the light, and did not return. Again, residents were reminded to share specific time/shift/aide so they could reeducate and talk with the staff, and nurse management was made aware.02/17/26 Old Business restated resident concern about staff on the third shift using their phones during work, not answering call lights or doing rounds.02/17/26 New Business documented that residents again had a concern that staff respond to call lights, turn them off saying they would return, but not returning. Residents stated this happened on all shifts. Residents again stated a concern with staff on third shift using their phones during work. It was reported that managers intended to come to the facility on the third shift to address the concerns, and that staff would all be educated at the next all-staff meeting.03/17/26 Old Business documented that residents had concerns with staff responding to call lights, turning them off stating they would return, but not returning. This was noted to occur on all shifts. It was also restated that residents had concerns with staff on the third shift using their phones during work.03/17/26 New Business reported residents had a concern with staff still using their phones (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while working.The facility failed to document resolution to the residents' concerns regarding staff using their phones while working, or staff response to call lights. The facility documented that management was made aware for multiple months without follow-up or additional information being provided to Resident Council that any additional steps had been taken. Staff placed additional responsibility on residents with concerns about call light response times and staff turning off lights, requesting they remember and document the situations prior to any indication that the facility would investigate the concern. The repeat nature of the residents' allegations of staff not properly responding indicated that no resolution was successfully attempted. Housekeeping Services:12/16/25 Old Business revealed that residents had reported that their rooms were not being cleaned daily, and that the tables on the second-floor dining room were not being cleaned.12/16/25 New Business documented that residents stated that their rooms were not being cleaned daily, and that the toilets were not being cleaned. It was documented that a TELS (facility management system) order was in place for maintenance. Additional new business documented that staff would now be responsible for cleaning off dining room tables.01/20/26 Old Business revealed resident rooms were not being cleaned daily, and toilets were not being cleaned. It was documented that maintenance was aware.01/20/26 New Business revealed residents stated that their bathrooms were still not being cleaned, especially the toilets. It was again stated that a TELS order was placed for maintenance and that Facility Service Manager (FSM) and Executive Director were aware. Residents were asked if the dining room on the second floor was being cleaned. Residents stated that it was dirty. It was documented that the FSM was made aware and would address it.02/17/26 Old Business documented that residents had expressed concerns that their bathrooms were not being cleaned. It was noted that residents were reminded that their rooms were cleaned, but if any bathrooms needed attention, residents should notify staff. It was also reported that residents were concerned with the second-floor dining room not being cleaned. It was recorded that in the previous meeting minutes the FSM was made aware and would address it.02/17/26 New Business did not document any concerns.03/17/26 Old Business did not document any concerns.03/17/26 New Business revealed residents stated that they noticed the floors in the dining room were not being cleaned after meals, and that their trash was not being removed. Documentation stated that the maintenance team would be notified. Residents were reminded that they could always bring concerns about room cleanliness to the staff.The repeated concerns by residents during Resident Council indicated that a resolution had not been followed up on or documented. The documentation that the FSM would put orders into TELS did not translate into housekeeping services being provided or maintained to meet the needs of the residents.During an interview on 04/15/26 at 12:30 PM, the Director of Nursing (DON) stated that if staff had to receive one-on-one education or on-the-spot training for an area of correction the staff member would usually be called into the office, where they would speak with them. The DON stated that they did not always document when retraining or reeducation was needed.During an interview on 04/15/26 at 3:44 PM, the Life Enrichment Director (LED) stated she scribed the minutes at the monthly Resident Council meetings. The LED said that they always recap the old business first, the previous concerns, by reviewing the different departments. She said that if residents have complaints, she will take the notes and meet with the DON, Executive Director, Maintenance and Admissions in a standing meeting after the Resident Council meeting. The LED said that after that the meeting notes and minutes will be shared with the department heads. She said she would keep in touch with the department heads before the next Resident Council meeting. During the next meeting, if the residents still bring up the Old Business as current concerns that were not fixed. The DON would be invited to talk to the residents. The LED said that with housekeeping concerns the FSM has started to put the concerns into the TELS system. The LED confirmed residents state that housekeeping services were not being kept up, so FSM communicates with the housekeeping staff to do the work. The LED confirmed that call lights have continued to come up, that the facility had been working on staffing and call lights for a few months, and was working on resolutions.During a (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent interview with the Executive Director and DON on 04/15/26 at 9:01 PM, the Executive Director stated that when there were repeated grievances or allegations it was important to complete a root cause analysis to determine the commonalities, to find the root cause. It was important to see what kind of systemic change could take place. The DON confirmed that it was important to also document when staff have had reeducation to correct a prior problem or action. They both agreed it was important to close the loop, the repeat nature of the concern.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to maintain a safe and homelike environment, including to ensure housekeeping services were conducted as necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, the facility failed to ensure floors were swept and cleaned of dirt and trash in common areas including dining rooms, on two of three units (B and D) hallways and resident rooms during three of three survey days. Specifically, this deficient practice had the potential to affect the residents quality of life in their rooms and common areas.Findings include:During an observation on 04/13/26 at 4:27 PM, the second-floor D unit dining room had papers and straws on dining room tables. The floor in this room had food debris, trash, and dirt scattered across the room and under dining room tables. During an observation on 04/14/26 at 11:00 AM through 11:24 AM, the second-floor D unit dining room floor had large black scuff marks throughout the room; straw wrappers, large accumulation of food and dirt debris under numerous resident dining room tables; used plastic cups and napkins were left on one dining room table, numerous napkins were left on the floor under another table, and a used cup and opened supplement drink were left on another table. Resident rooms 222, 224, 226, 231, and 232 had dirt, debris, and trash on the floor. During an observation on 04/14/26 at 11:29 AM, the first-floor B unit dining room revealed paper placemats and silverware placed on dining room tables for lunch services. The dining room floor was observed with extensive food and dirt debris throughout the room, including below dining room tables. Dark scuff marks were observed on the floors. There was dark residue built up around the floor perimeter under the small hydration refrigerators. During an observation on 04/14/26 at 4:26 PM, the second-floor D unit dining room revealed paper placemats and silverware placed on the dining room tables for dinner. Underneath multiple tables were food debris and trash; the same items identified during an earlier observation.During an observation on 04/14/26 from 4:13 PM through 4:25 PM on D unit, resident rooms 222, 223, 224, 226, 231, 232, 234, 237, and 243 had dirt and trash on the floor. Soiled napkins were on the hallway floor outside room [ROOM NUMBER]. Dirt was observed throughout the hallway floor.During an observation on 04/15/26 at 10:58 AM, the first-floor B unit dining room had paper placemats and silverware placed for lunch. The floors had significant dirt and debris under residents' dining tables.During an observation of resident rooms on 04/15/26 from 11:00 AM through 11:10 AM on Unit B, resident rooms [ROOM NUMBERS] had food and trash on the floor. The B unit hallway floor had significant dirt and debris.During a concurrent interview on 04/14/26 at 9:28 PM, Licensed Practical Nurse (LPN) 1 and Certified Nursing Assistant (CNA) 1 stated that there were only two housekeepers at the facility, and that housekeeping services were not being completed as they should be. LPN1 and CNA1 said that the upstairs dining room would only get cleaned if the CNAs swept itDuring an interview on 04/15/26 at 12:40 PM, housekeeper (HSKP) 1 stated that they worked in all areas of the facility. HSKP1 said that they often worked alone and that HSKP2 did not work today. They would start upstairs and spot clean and then go down to the first-floor units and do the best they could. HSKP1 confirmed their shift ended at 2:30 PM and HSKP2's shift would end at 4:00 PM.During an interview on 04/15/26 at 2:35 PM, the Facility Service Manager (FSM) stated that there used to be three housekeepers at the facility, but now there were just two. FSM confirmed that he had not given specific locations for the housekeepers to clean, just that they should share the units and collaborate. FSM said that the two housekeepers were responsible for cleaning all common areas and residents' rooms. FSM confirmed that he did not use a checklist or assignment log. During an interview on 04/15/26 at 3:44 PM, the Life Enrichment Director confirmed that residents had mentioned that housekeeping services had not been completed properly during multiple Resident Council meetings.During an interview and facility tour on 04/15/26 at 5:10 PM, the Executive Director confirmed that he had been rounding the facility and had seen some of these housekeeping concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Executive Director stated that he was not aware that the FSM did not have a checklist or direct assignment established for the housekeeping staff and said that it would be hard for housekeeping staff to know what their responsibilities would be like without additional information. The Executive Director revealed that there was no current policy regarding housekeeping services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to report an allegation of abuse for one (Resident (R) 9) of one abuse allegation reviewed in the sample of 12 residents to the State Agency (SA) immediately, but no later than 2 hours after the incident. This failure had the possibility to negatively impact residents currently residing at the facility. Findings include:Review of the facility's policy titled, Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program revised 02/11/26 indicated, . G. Reporting and Response: 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.are reported immediately, but not later than 2 hours after the allegation is made.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.Review of R9's admission Record in the electronic medical record (EMR) under the Census tab revealed R9 was admitted to the facility on [DATE] with the diagnosis of anxiety disorder and metabolic encephalopathy. Review of R9's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/11/25 located in the EMR under the MDS tab with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated R9 was cognitively intact. The MDS did not indicate that R9 had a pressure ulcer.Review of the facility provided, Report of Grievance dated 01/12/26 indicated, . [R9] reports that Certified Nursing Assistant (CNA) [meaning CNA1] took picture of her buttocks wound on 01/05/26 or 01/06/26.Investigation Findings: CNA1 showed R9 a Goggle image of similar but worse buttock wound to R9 on 01/05/26 to demonstrate how wearing briefs at night could worsen R9's wound. CNA1 stated to R9 that her wound looks better and denies taking photo of R9. Resolution Description: Staff educated on keeping phones outside of R9's room, and pictures of residents should not be taken. Review of facility provided Grievance Log dated 01/26 verified that this grievance was not sent into the SA. Review of facility provided Facility Report Investigations (FRI) reports from 12/01/25-present revealed no evidence of this grievance being reported to the SA. During interview on 04/14/26 at 5:25 PM, CNA1 stated that she recalls R9 having a wound on her buttocks/coccyx area and speaking to R9 (did not recall the date) about doing what staff asked her to do regarding her wound. CNA1 said that one intervention was that R9 had been asked not to wear her briefs to bed at night and she had been noncompliant with this. CNA1 said she thought she was helpful by showing R9 a Google image of what her buttocks could look like. However, CNA1 denied taking a photo of R9's bottom. During interview on 04/14/26 at 5:51 PM with Social Services (SS) 1 and SS2, both confirmed what was written on the grievance form and both confirmed that the interdisciplinary (IDT) determined this was not abuse, so there was no need to report to the SA within two hours. Interview on 04/14/26 at 6:00 PM, the Director of Nursing (DON) could not state what was to be reported to the SA within two hours. Attempted interview with Administrator on 04/14/26 at 6:10 PM; however, he refused to answer any questions. Interview on 04/15/26 at 11:50 AM, the Admissions/Former Administrator confirmed that this grievance was not seen as an allegation of abuse because the facility staff talked with CNA1 who claimed she was just talking with R9 and that she did not take a photo of R9's buttocks on her phone. When asked what is reported to the SA, she stated if the resident said a staff member hit them, did not care for them or did anything derogatory to them. She then stated whatever the definition of abuse is. She stated that grievances/incidents are reported depending on how they are investigated. Each individual situation is different.

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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, record review, and policy review, the facility failed to thoroughly investigate an allegation of abuse for one (Resident (R) 9) of one resident reviewed for abuse in the sample of 12 residents. This failure had the potential to negatively impact all residents currently residing at the facility. Findings include: Review of the facility's policy titled, Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program revised 02/11/26 indicated, .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 Quality Assurance and Performance Improvement (QAPI) 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. 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.iv. Involved staff and witness statements of events.F. Protection.It is the policy of this facility that the resident (s) will be protected from the alleged offender (s).Review of R9's admission Record in the electronic medical record (EMR) under the Census tab revealed R9 was admitted to the facility on [DATE] with diagnoses of anxiety disorder and metabolic encephalopathy. Review of R9's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/11/25 located in the EMR under the MDS tab with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was cognitively intact. The MDS indicated that R9 had no psychosis, no behavioral symptoms, and no behavior of resisting care and/or medications. The MDS did not indicate R9 had a pressure ulcer.Review of facility provided, Report of Grievance dated 01/12/26 indicated, . R9 reports that CNA1 took picture of her buttocks wound on 01/05/26 or 01/06/26.Investigation Findings: CNA1 showed R9 a Goggle image of similar but worse buttock wound to R9 on 01/05/26 to demonstrate how wearing briefs at night could worsen R9's wound. CNA1 denies taking photo of R9. The facility's Social Services (SS) 1 and SS2 did not provide any evidence that this grievance was investigated. The facility's Admission/Former Administrator did not provide any evidence that there was any staff education about keeping phones outside of residents rooms and that pictures of residents are not to be taken. Interview on 04/14/26 at 5:25 PM, CNA1 denied taking a picture of R9's bottom. CNA1 stated that she showed R9 a Goggle picture of a wound that appeared to be worse than R9's wound indicating to R9 what could happen if she remained non-complaint with the intervention of not wearing briefs at night. During interview on 04/14/26 at 5:51 PM with SS1 and SS2, both confirmed that during the investigation of this grievance, CNA1 and multiple staff were interviewed, including CNA1; however, confirmed there was no documentation. Both confirmed that no residents were interviewed. Administrator attempted to be interviewed on 04/14/26 at 6:10 PM but refused to answer any questions by the survey team regarding this grievance. Interview on 04/15/26 at 11:50 AM, the Admissions/Former Administrator confirmed that after this incident staff were re-educated about not having phones in residents' rooms. However, when asked for documented evidence, the facility did not provide evidence of an investigation.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and document review, the facility failed to ensure that the planned menus were followed as approved, scheduled, and posted. As a result, a pattern of 53 residents who received food prepared by the facility were not provided with the portion size as indicated on the planned menu. These failures placed facility residents at risk for weight loss, malnutrition, and dissatisfaction with their meals.Findings include:1. During an observation on 04/14/26 at 4:46 PM, the approved menus for the lunch meal revealed the following portion sizes: #8 scoop (4oz.) for mashed potatoes, apple crisp, mechanical chicken, ground chicken, carrots, and the chef choice vegetables; gravy at 2 oz.; and chicken cordon bleu, one each for regular.Review of the Portion Control Char, posted in the kitchen and in the first-floor satellite kitchen indicated that the #8 scoop (4 oz.) is identified as a gray color, #12 scoop (2 2/3 oz.) is identified as a green color, and the #16 (2 oz.) is identified by its blue color.During an observation of lunch service on 04/14/26 at 11:39 AM through 12:40 PM, the steam table in the first-floor satellite kitchen steam table contained: mashed potatoes, gravy, chicken cordon bleu, chef choice vegetables, carrots, apple crisp, mechanical and ground chicken.During lunch service on 04/14/26, Dietary Aide (DA) 1 was observed serving the meal with the following incorrect portion sizes: chicken cordon bleu mechanical and ground, carrots, and mashed potatoes were served with the #12 green scoop; the chef choice vegetables were served with the #16 blue spoodle (cross between a serving spoon and a ladle). Each item was underserved according to the menu.2. During an observation on 04/14/26 at 4:46 PM, the approved menu for the dinner meal indicated the following portion sizes: #8 scoop (4oz.) for creamy coleslaw, one grilled cheese sandwich and chocolate crispy bar, and 6 oz. of tomato soup.During an observation of dinner service on 04/14/26 at 4:48 PM, the steam table in the first-floor satellite kitchen was prepared for dinner with the following foods: tomato soup, creamy coleslaw, grilled cheese sandwiches, and chocolate crispy bar.During dinner service on 04/14/26 at 4:48 PM to 4:54PM, DA2 was observed serving the meal with the incorrect portion size for the tomato soup. DA2 used a 4 oz. soup ladle. DA2 confirmed that a 4 oz. soup ladle was used instead of the 6 oz soup ladle. DA2 stated that they used the recipes to determine what size scoop or ladle to use during mealtimes.During an interview on 04/15/26 at 4:13 PM, the Registered Dietitian (RD) stated most residents were on a regular diet. They said that they signed off on the extensions each week, and that the portion sizes were documented there. The RD confirmed that the kitchen used the universal equipment for portion standards. The RD said that they wanted the kitchen staff to follow the portion sizes that they had approved.During an interview on 04/15/26 at 5:10 PM, the Executive Director stated that the facility could not find a policy on following approved menus. He stated that menus would be followed by the Dietary department.During an interview on 04/15/26 at 6:04 PM, the Dietary Manager said that education and training was done every three or four months to ensure the dietary staff had training on the steam table, and which scoops to use. The DM confirmed that the DA had informed him that they had used the 4 oz. soup ladle for the previous dinner and not the appropriate 6 oz ladle. The DM said that the lunch meal on 04/14/26 portions were underserved.During an interview on 04/15/26 at 6:22 PM, the Director of Nursing (DON) stated that it was the expectation that the Dietary department would serve meals to the residents according to the approved menus.