

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 4 out of 7 residents (R2, R43, R1, R39) who were at risk for falling received the appropriate interventions to prevent further falls from occurring. The facility did conduct a thorough investigation of R2's falls on 5/11/26, 5/23/26, 6/2/26 and 6/4/26. The facility did not update the plan of care with additional interventions that could prevent R2 from future falls and injuries. R43 experienced a fall on 5/21/26 and 6/7/26. The facility did not thoroughly investigate and update R43's plan of care with interventions that could prevent R43 from future falls and injuries. The facility did not conduct a thorough investigation after R1 had a fall on 7/13/26. R39's falls care plan documented a call don't fall sign implemented 12/8/25 which was not observed to be in place. R39 had a fall on 3/31/26 and the interdisciplinary team (IDT) determined an appropriate intervention was to apply Dycem to the wheelchair, which was an intervention in R39's care plan effective 1/17/26. This is evidenced by: Policy review: Falls, last review date 4/9/26, which documents Prevention measures are put in place to reduce the occurrence off falls and risk of injury from falls. 1. Procedure: Fall Risk.a. Licensed nurse will complete an electronic Fall Assessment upon admission.b. A licensed nurse will complete a Fall Assessment quarterly, or with change in condition.c. A licensed nurse will determine the individual's risk for falls and individualized care needs. If the individual is at risk for falls, then create a falls care plan. 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 (RN) reviews and completes the fall assessment and interventions.d. Fall follow-up assessment completed as indicated. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 1.) R2 was admitted to the facility on [DATE] with diagnosis that include traumatic brain compression, vascular dementia, adult failure to thrive and repeated falls. On 4/13/26, the facility conducted an admission fall risk assessment for R2 which documented a score of 15, indicating R2 is at risk for falls. Surveyor conducted a review of R2's individual plan of care which documents: R2 is high risk for falls r/t (related to) history of falls, confusion, recent wander. Date Initiated: 04/13/2026. Interventions included: Risk of falls/falls with injury will be minimized. Date Initiated: 04/13/2026 5/11/2026: dycem to wheelchair. Date Initiated: 05/12/2026 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 forAssistance. Date Initiated: 04/13/2026 Call don't fall sign. Date Initiated: 04/16/2026 Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 04/13/2026 Ensure that the resident is wearing appropriate footwear non-skid socks when ambulating, transferring or mobilizing in w/c (wheelchair). Date Initiated: 05/12/2026 Follow facility fall protocol. Date Initiated: 04/13/2026. R2 has an ADL (activities of daily living) self-care performance deficit due to activity intolerance, hip fracture, skull fracture cognitive impairment, terminal. Date intitated 4/13/26. Interventions included:*Transfer: R2 is able to ambulate in the room, to/from the bathroom with 2 wheeled walker and the assist of 1. *Encourage R2 to use bell to call for assistance. Date initiated: 4/20/26. The plan of care identifies R2 has urge bladder incontinence due to activity intolerance and confusion. Interventions did not include any type of toileting plan or assistance level needed. R2's significant change MDS (minimum data set), dated 6/17/26 documents R2 has a BIMS (brief interview for mental status) score of 6, indicating severe cognitive impairment. R2 has had 1 fall since admission and no injuries as a result of the fall. Nursing note dated 5/11/2026 at 10:53 PM; R2 found on the floor sitting on her buttock on the floor. R2 called 911 for assistance. Writer entered the room with the fire dept. (department) and resident reported I'm sorry, I couldn't reach my call light from here so I had to call them R2 denies hitting head, dept picked up R2 and put her into bed. R2 demonstrated range of motion without difficulty or pain, completed skin check, no areas of concern, or skin tears, no edema, clubbing or hematomas noted. Started neuro (neurological), checks updated Nurse Practitioner, Manger on Duty, hospital and family. Will continue to monitor. Surveyor conducted a review of the facility's falls investigation for the fall that occurred on 5/11/26 at 10:00 PM which documented R2 was sitting on floor sitting on her buttocks. R2 called 911 because (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she couldn't reach call light. R2 moves around self propels in room and couldn't find the call light. The root cause was identified as R2 sliding from wheelchair while mobilizing with wheelchair in room. New intervention: Dycem applied to wheelchair to reduce sliding risk and promote safe positioning. Surveyor noted the investigation did not include any staff statements regarding the last time R2 had received cares or if falls interventions were in place at the time of the fall. Surveyor noted on 5/11/26, Dycem to wheelchair for safety was added to the Certified Nursing Assistant Kardex and the falls plan of care. Nursing note dated 5/23/2026 at 12:27 PM, documents R2 sustained UWF (unwitnessed fall). After receiving call for help from CNA (Certified Nursing Assistant), Writer found R2 lying on the floor on her back. There was a small pool of blood next to her and a noted laceration to the left eye. Writer asked if R2 was in pain anywhere , R2 stated just my head. Writer then asked her what she was trying to do, she said go to the bathroom. We assisted R2 back to bed and left to call the ambulance and update family/Supervisor/Physician. Surveyor conducted a review of the facility's falls investigation for the fall that occurred on 5/23/26 at 7:30 AM. CNA called to room for help, when Nurse walked into the room, Nurse witnessed R2 laying on her back on the floor next to her wheelchair. There was a small pool of blood where her head was and blood coming from a laceration on her eyebrow. R2 stated she was trying to go to the bathroom. Injury-laceration to face. Transferred to hospital. R2 tried to self-transfer, did not lock the wheelchair. IDT team met. R2 observed lying on her back on the floor next to her wheelchair, Blood was noted beneath the residents (sic) head with active bleeding from a laceration to eyebrow. Res (Resident) has been attempting to self-transfer at the time of the fall, Emergency services were activated, Root Cause-unassisted self-transfer. Surveyor noted the fall investigation did not indicate the last time R2 was toileted although it's documented that R2 was last seen by the Nurse at 6:30 AM on 5/23/26. R2 was incontinent of bowel and bladder at the time of the fall. No additional interventions were added to the care plan. Nursing note dated 6/2/2026 at 09:59 AM, documents R2 notified writer that she fell last night and got herself back to bed, however she is unsure if she notified the overnight RN. R2 reporting right forearm pain, very mild redness to the elbow, however full range of motion present without pain to the elbow. R2 is alert and orientated times 2. Pupils are equal and reactive, strength equal in the extremities. No signs of trauma. Vital signs stable and Nurse Practitioner- H notified. Is understanding and stated she will see R2 today. On 7/22/26, Surveyor requested to review the falls investigation for R2's fall on the evening of 6/1/26. Clinical Consultant- C confirmed the facility did not conduct a falls investigation, update the plan of care or obtain any staff statements for this unwitnessed fall. Nursing note dated 6/4/2026 at 06:26 AM, documents CNA called and informed writer R2 was found on the floor at the front of the nursing station. R2 was observed, lying down on the floor facing couch at front of nursing station with her back on her wheelchair. R2 stated she was looking for her family and when she did not see them R2 tried to transfer self to the couch and slid to the floor. Upon assessment, no bruise or injuries noted. Range of motion within normal limits. Neuro-checks started (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R43's individual plan of care and noted the following: R43 is at risk for falls r/t (related to) Confusion, weakness, Gait/balance problems and history of falls, foot pain, dementia, fall 2/22/26. Date Initiated: 06/24/2024. Revision on: 02/23/2026. Interventions included: Risk of falls/falls with injury will be minimized. Date Initiated: 06/24/2024. 4/5/25-fall-staff to offer toileting q (every) 2 to 3 hours and as needed. Date Initiated: 04/05/2025 6/7/26: Reacher at bedside. Date Initiated: 06/08/2026. Be sure R43's call light is within reach and encourage R43 to use it for assistance as needed. Date Initiated: 06/24/2024. fall-5/25/25-staff to ensure resident not attempting to feed others when dining room. Date Initiated: 05/25/2025. Follow facility fall protocol. Date Initiated: 12/12/2025. Toilet resident after dinner Date Initiated: 02/22/2026. Nurses note dated 5/21/2026 at 11:51 PM, documents R43 had a fall at approximately 10:40 PM. R43 states she thought it was morning at the time of the fall. Vital signs stable. Neuro (neurological) checks initiated and ongoing. No visible injuries noted upon assessment. Director of Nursing notified. Physician notified. Hospice notified. Surveyor conducted a review of the facility's falls investigation dated 5/21/26. The investigation documents a staff statement was obtained on 5/27/26 (name unknown). Statement is that while in the hallway with another nurse, R43 was heard yelling. Upon entering the room, R43 was observed sitting upright on the floor with a pillow positioned under her knees/legs. R43 stated she thought it was morning and was attempting to get ready. Vital signs were obtained, and no injuries were noted upon assessment. R43 denied hitting her head. Surveyor noted there was no additional information regarding the last time R43 had been cared for and what fall prevention interventions were in place at the time of the fall. Surveyor requested to review this falls investigation on 7/21/26. The investigation had a note added on 7/21/26 written by Director of Nursing (DON)- B stating R43 experienced a fall at approximately 10:40 PM. R43 believed it was morning at the time of the fall. Suggesting impaired orientation to time. Root cause: impaired orientation regarding time of day. Interventions: maintain a low-stimulation environment overnight by turning off room lights at bedtime while ensuring adequate night lighting for safe mobility and keep call light in reach. Surveyor noted these interventions were not added to the plan of care and R43 was assessed to require substantial/maximal assistance from staff for mobility. Nursing note dated 6/7/2026 at 2:25 PM, documents Writer called to room. R43 on floor sitting on her butt, next to recliner with w/c (wheelchair) behind her, R43 was just placed in w/c by CNA (Certified Nursing Assistant). Call light in place, R43 had an unwitnessed fall from w/c to floor. R43 stated she was trying to reach for something. R43 was found alert with confusion per normal baseline, ROM (Range of Motion) WNL (Within Normal Limits), neuro (neurological) check negative, denies any additional pain other than the raised bump on the left side of her forehead about 5cm (centimeters) x (by) 4cm, ice applied, VSS (Vital Signs Stable), R43 transferred from floor to bed with 2 assist, Hospice on call notified, Hospice will come to SNF (Skilled Nursing Facility) to visit R43, message left for Dr. (Doctor) to update on fall. Power of Attorney updated on fall. On 6/7/2026 at 2:45PM, the facility completed a Skin Evaluation and documented the following: Skin warm & dry, skin color WNL, mucous membranes moist, turgor normal. R43 has current skin issues. Skin Issue: Bruising. Skin issue location: left forehead Length: 5cm Width: 5cm Tissue: Painful. Note / Notification / Education: Skin note: bumped head on floor. Provider Contacted: Time Notified: 246p (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2:46 PM) Notification Details: message left. Person Contacted: Power of Attorney. Time Notified: 246pm (2:46 PM) Notification Details: n/a (not applicable). Resident / Responsible Party aware of diagnosis and plan of care: Yes. Resident education provided R/T (related to) new diagnosis: Yes. Resident education provided R/T new order: Yes. Education provided in preparation for discharge: Yes. Other Education Notes: n/a. On 7/21/26, Director of Nursing (DON)-B provided hospice communication regarding R43's fall on 6/7/26. DON- B stated the hospice RN arrived on 6/7/26 at 3:36 PM (approximately 2 hours after fall). The following was noted: Client Coordination Note Report dated 6/7/26; PM staff (facility staff) reports that R43 had a fall while she was sitting in her wheelchair. They (facility) report that R43 fell forward and hit her head. Fall unwitnessed. R43 obtained bump and bruise to left forehead and temple. No skin tear or wounds obtained. Vital signs stable. Per medication profile, R43 is taking Eliquis (anticoagulant/ blood thinner). R43 is sleeping on arrival and doesn't wake up to answer questions. Staff (facility) report R43 had Ativan. Surveyor reviewed June 2026 Medication Administration Record and noted Lorazepam 0.5 milligram tablet by mouth every 2 hours as needed for anxiety was administered on 6/7/26 at 9:00 AM, and 12:00 PM/noon. Fall Mat in place. Bed in low position. Remote within reach. Writer offered to obtain a Broda chair. They declined at this time. R43 has wheelchair in that (sic) is used to pedal around floor. Writer attempted to contact Power of Attorney, no answer and voicemail left to call with update, Fax sent to Nurse Practitioner . Fall education provided. They (facility staff) know to call with questions or concerns. R43 will be made in medical examiner case in relation to hitting her head. Surveyor verified Neuro checks were completed on 6/7/26 per facility's policy. R43 appeared to be at baseline. Surveyor conducted review of the following days nursing notes and there was no documentation regarding a change in mentation or pain from fall on 6/7/26. Hospice Progress note dated 6/8/26, documents RN (hospice) contacted Nurse Practitioner to updated on R43's fall. No new orders. RN to confirm with R43's Activated Power of Attorney if he/she is ok to discontinue Eliquis and let Nurse Practitioner know. Surveyor conducted a review of the facility's falls investigation dated 6/7/26. The post fall huddle form documents the fall occurred at 1:50 PM on 6/7/26. R43 was said to be reaching for her purse. R43 was documented to be seen 5 to 10 minutes prior to fall to be toileted. R43 had gripper socks on. R43 was not incontinent of bowel or bladder at the time of the fall. Was care plan being followed- yes. Was call light on- yes. Staff statements were obtained. Certified Nursing Assistant stated that they heard yelling and instantly went over and saw R43 on the floor trying to grab purse. Staff intervention was to put R43 back to bed and gave ice pack. It was documented as an intervention suggestion that the nurse told the Certified Nursing Assistant to put R43 back to bed and the nurse checked her vitals and gave R43 an ice bag. On 6/8/26 the Interdisciplinary Team met regarding R43's fall on 6/7/26, documented was R43 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concern with DON-B and CNC-C that a thorough investigation was not completed for R1's fall on 7/13/26, and DON-B and CNC-C replied they were not sure why a complete investigation was not completed for that fall. 4.) R39 was admitted to the facility on [DATE] with diagnoses including depression, orthostatic hypotension, Type 2 Diabetes Mellitus, muscle weakness, other abnormalities of gait and mobility, repeated falls, and unspecified dementia. R39's admission Minimum Data Set (MDS) assessment dated [DATE] documented R39 had a fall in the last month and R39 required maximal assistance for transfers in and out of the wheelchair. R39's Care Area Assessment (CAA) for falls dated 11/17/25 documented a fall score of 13, indicating at risk for falls, proceed to care plan, at risk due to dementia and in new environment. R39's care plan for focus area at risk for falls initiated 11/10/25 documented the following interventions: -be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Resident needs prompt response to all requests for assistance -call don't fall sign placed in room (12/8/25) -dycem placed under wheelchair cushion (1/17/26) -educate resident/family/caregivers about safety reminders and what to do if a fall occurs -ensure resident is wearing appropriate footwear non-skid socks when transferring or mobilizing in wheelchair (12/10/25) -follow facility fall protocol (12/10/25) -resident encouraged to stay at the nurse's station/with staff for closer supervision (1/21/26) -resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; personal items within reach (12/10/25) On 7/21/26 at 7:52 AM, Surveyor observed R39's room and did not observe a call don't fall sign anywhere in the room. On 7/22/26 at 7:54 AM, Surveyor observed R39's room and did not observe a call don't fall sign anywhere in the room. On 7/21/26 at 10:10 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-O, who stated R39 is a fall risk and gets antsy in bed and in the wheelchair. CNA-O stated staff checks on R39 often and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Lindengrove Menomonee Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	keep R39 in common areas during the day to prevent falls. CNA-O stated R39 does not really use the call light. CNA-O was not aware if R39 should have a call don't fall sign in their room. On 7/22/26 at 11:34 AM, Surveyor reviewed R39's fall investigations dated 1/17/26 and 3/31/26. R39's fall investigation dated 1/17/26 documented a root cause of sliding out of the wheelchair, and the IDT (Interdisciplinary Team) identified a new intervention of placing dycem under R39's wheelchair cushion to prevent further sliding would be appropriate. R39's fall investigation dated 3/31/26 documented a root cause of sliding out of the wheelchair due to poor positioning and stability, and the IDT determined a new intervention of dycem applied to R39's wheelchair to prevent sliding and promote stability. Surveyor notes the intervention of adding dycem to R39's wheelchair was added to R39's falls care plan on 1/17/26 and should have been in place at the time of R39's fall on 3/31/26. On 7/22/26 at 1:55 PM, Surveyor interviewed Director of Nursing (DON)-B, who stated R39's fall care plan interventions include a call don't fall sign in room, dycem to the wheelchair, proper footwear with non-skid socks, encourage to stay at nurse's station for supervision, and call light within reach. DON-B stated the call don't fall sign was implemented 12/8/25 and the dycem to the wheelchair was implemented 1/17/26. Surveyor shared concern with DON-B and Clinical Nurse Consultant (CNC)-C of observations of a call don't fall sign not being in place in R39's room and that R39's fall investigation on 3/31/26 documented a new intervention of dycem to the wheelchair, which was implemented on 1/17/26. CNC-C stated they would follow up with Surveyor regarding additional clarification of the dycem, but no additional information was provided.		

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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 interview and record review, the facility did not ensure injuries of an unknown source were reported immediately, but not later than 24 hours after the event, to the State Agency for 3 of 3 residents (R1, R44, R43) reviewed for injuries of unknown origin from a sample of 12 residents. R1 was found by a family member with bruising and swelling the left ankle. The facility did not report the injury of unknown origin to the State Agency. R44 had an injury of unknown origin reported to staff by a family member on 7/6/26, which was not reported to the Nursing Home Administrator (NHA) until 7/11/26. R43 was found with bruising to the forehead. The facility did not report the injury of unknown origin to the State Agency. Findings include: The facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property with approval date 8/28/17 and review date 2/11/26 documents: . 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, 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, if 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 .) in accordance with State law through established procedures. 1) R1 was admitted to the facility on [DATE] with diagnoses including anemia, and unspecified dementia. R1 had an activated power of attorney (POA) for healthcare decisions. On 7/20/26 at 1:18 PM, Surveyor spoke with R1's POA via phone call who stated R1 has had quite a few falls since being at the facility and the facility stated there were no injuries, however, when they came to visit R1 on 7/14/26, they noticed R1's foot was swollen and bruised. R1's nursing progress note dated 7/13/26 documented an unwitnessed fall at 6:45 AM, R1 was found on the floor mat in front of the bed on knees, no injuries noted. Surveyor reviewed R1's electronic health record (EHR) and located an x-ray report dated 7/14/26 which documented the following: left foot x-ray, no acute findings . left ankle x-ray, no acute findings, soft tissue swelling noted around the ankle. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor did not locate any nursing progress notes regarding bruising or swelling of R1's left foot or ankle on 7/14/26. R1's skin only evaluation dated 7/14/26 documented skin color within normal limits (WNL), no current skin issues. R1's skin monitoring: comprehensive shower review document dated 7/14/26 documented no new skin issues noted. Surveyor notes both the skin only evaluation and skin monitoring document were completed and signed by Licensed Practical Nurse (LPN)-F. On 7/22/26 at 8:30 AM, Surveyor interviewed LPN-F who stated when they assessed R1's skin on 7/14/26, they did not see any bruising or swelling, and R1 has never had any bruising or swelling on the left ankle. LPN-F did not recall R1 ever getting an x-ray on the left foot or ankle on 7/14/26. On 7/21/26 at 10:18 AM, Surveyor interviewed Hospice Registered Nurse (RN)-G who stated they saw R1 on 7/14/26 when R1's POA was at the facility and noted R1's left foot was swollen and blue. Hospice RN-G stated R1 did have a fall the day prior, but they were not sure if the swelling was from the fall or not. Hospice RN-G stated R1's Nurse Practitioner (NP) and Medical Doctor (MD) were both at the facility that day and looked at R1's foot and R1's MD ordered an x-ray. On 7/21/26 at 11:09 AM, Surveyor interviewed NP-H who confirmed they saw R1 on 7/14/26 after it was brought to their attention by Hospice RN-G that R1 had swelling and bruising on the left foot and ankle region and R1's MD ordered an x-ray that day, which came back negative for any fractures. NP-H stated there was not any notification from the facility regarding R1's bruising or swelling, and NP-H was only made aware of the swelling and bruising from Hospice RN-G. On 7/22/26 at 2:04 PM, Surveyor shared concern with Director of Nursing (DON)-B and Clinical Nurse Consultant (CNC)-C that R1 was found with bruising and swelling of the left ankle on 7/14/26, which was not reported to the State Agency as an injury of unknown origin. DON-B and CNC-C stated they would look into it and get back to Surveyor. On 7/23/26, Surveyor was provided with a document titled Client Coordination Note Report written by Hospice RN-G, with print date 7/22/26 at 3:25 PM. The report documented visit completed, R1's POA noted left foot swollen with trace edema. MD rounded on R1 and ordered an in-house x-ray. On 7/23/26 at 12:21 PM, Surveyor shared concern with NHA-A that R1 had a fall on 7/13/26 which the facility documented did not result in any injuries, and R1's skin assessments dated 7/14/26 documented no skin abnormalities, however, R1's hospice RN, NP, and MD were made aware of bruising and swelling to R1's left ankle on 7/14/26, which was not reported to the State Agency as an injury of unknown origin. NHA-A stated they believe the bruising and swelling were a result of R1's fall the day prior, but the facility did not document on the injury appropriately. NHA-A stated the facility should have documented better to determine if R1's bruising and swelling were from the fall or from an unknown event. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) R43 was admitted to the facility on [DATE] with diagnosis that included Dementia and Anxiety. R43's quarterly MDS (Minimum Data Set), dated 5/22/26, documents R43 has a BIMS (brief interview for mental status) score of 6 indicating severe cognitive impairment. R43 is also assessed to have 1 fall since admission without injury and no noted behavior concerns. Nursing note dated 6/11/26 at 5:34 AM, Skin Evaluation: Skin warm & dry skin color WNL (within normal limits), mucous membranes moist, turgor normal. [R43] has current skin issues. Skin Issue: Bruising. Skin issue location: left eye / forehead Length: 2cm (centimeters) x (by) 2cm Tissue: Painful. Note / Notification / Education: Skin note: RN(Registered Nurse)- [I] entered R43's room to do assessment, while doing vital signs , RN- [I] noticed [R43] in bed awake, [R43] had no O2(oxygen) in place , RN- [I] placed O2 on [R43] at 3L (liters) N/C (nasal cannula) , POX (pulse oximetry) - 91% , resp (respirations)- 20 , no SOB (shortness of breath) - bilateral lungs clear , RN-[I] changed [R43's] brief with skin cares, provided fluids, during assessment RN-[I] noted a large bruise / discoloration of yellow / blueish / green to left facial area and forehead with 2cm x 2cm hematoma - no O/A (open area) visible , [R43] can't recall if she fell today. On Jun 09, 2026 &ndash; [R43] did not have any facial bruising or discoloration during NOC (night shift) shift between 2200pm (10:00 PM) - 06am (6:00 AM). Nurse Practitioner- [H] made aware via text message, on call Supervisor made aware via text message, Hospice made aware at 4:00 AM left message, VSS (vital signs stable), neuro. (neurological) check x2 - wnl, PRN (as needed) meds (medication)effective for comfort, bed placed in low position with soft touch call light. On 7/22/26 at 12:15 PM, Surveyor interviewed Director of Nursing- B regarding R43's left facial and forehead bruising and hematoma. DON- B stated she was not in the facility at this time and would need to check into concern further. Surveyor reviewed the nursing note from 6/11/26 regarding the findings and noted facility staff member reported on 6/9/26, during NOC shift the bruising was not present. Surveyor asked DON- B if this injury should have been reported as an injury of unknown source. DON- B replied yes it should have been reported. On 7/22/26 at 12:45 PM, Surveyor interviewed RN Nurse Supervisor-D regarding R43's bruising that was discovered by RN- I on 6/11/26. RN Supervisor-D provided Surveyor with documentation regarding R43's fall on 6/7/26. The incident description documents R43 had an unwitnessed fall from the wheelchair to the floor. R43 denied pain other than the raised bump on the left side of her forehead about 5 centimeters by 4 centimeters. Ice was applied. Documented injuries reported for this fall was a bruise to the top of the scalp. Surveyor reviewed the comparison between the injuries noted from the fall on 6/7/26 and the injuries noted by staff on 6/11/26. Surveyor noted staff worked 6/9/26 and documented the injuries were not present. RN Supervisor- D stated she recalls talking about the fall 6/7/26 but did not have any additional information as to why a further investigation was not completed and reported to the State Survey Agency. 07/23/2026 9:24 AM Surveyor left a voicemail message for RN-I to return call to discuss R43's bruises that were discovered on 6/11/26. RN- I is no longer employed by the facility and did not return Surveyors phone call. As of the time of exit on 7/23/26, the facility was unable to provide additional information as to why (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R43's bruising to the left eye and forehead was not reported to the State Survey Agency. 2) R44 was admitted to the facility on [DATE] with diagnoses to include stroke, metabolic encephalopathy, abnormalities to gait and mobility and dementia. R44's Comprehensive Minimum Data Set (MDS), dated [DATE], documented R44 has a Brief Interview for Mental Status (BIMS) score of 01, indicating severe cognitive impairment. R44 was assessed to be at risk for falls. R44 is dependent on staff for assistance with mobility. R44's Nurse's Note, dated 7/11/2026 at 13:13 (1:13 PM), documented, Writer made aware of resident noted bruising to top of right hand fourth digit knuckle area and random area of discoloration to right forearm and an area on left forearm along with small skin shear to left knee. Writer assisted with rom (range of motion) to digits of affected hand and resident did not grimace, wince or flinch in pain or discomfort. R44 did not respond when asked if they were in pain. Rom per baseline to left knee without difficulty DON (Director of Nursing), ADON (Assistant Director of Nursing), NP (Nurse Practitioner) updated, received order for 2 view x-ray of wrist and hand. Ice pack applied for comfort. Writer updated POA (Power of Attorney) and notified them of new order for x-ray. POA (Power of Attorney) grateful for f/u (follow up) care. DON, ADON, NP and Administrator notified. Will continue with plan of care and keep family updated. The facility's Investigation Summary, dated 7/17/26, documented, in part .Assistant Director of Nursing (ADON)-D was contacted by Licensed Practical Nurse (LPN)-J on 7/11/26 and was informed that bruises and swelling were observed on resident. Resident was unable to describe the cause of the bruising and was unable to identify a staff member that was working with R44 when any incident may have occurred. Administrator was notified and investigation of an injury of unknown origin was initiated. Police were also notified. Several staff statements were completed. One of the staff statements, an aide stated Certified Nursing Assistant (CNA)-M stated the family informed them of bruises on 7/6/26. The CNA-M stated that they informed LPN-L, of the bruises on 7/6/26. During an interview with LPN-L they stated no one made them aware of the bruising or swelling. Resident was assessed by nursing on 7/11/26 and was sent to the hospital to be further evaluated. Police report will be forwarded upon completion. Through multiple interviews with staff and residents, the facility was unable to determine a cause of the injuries. It appears that the bruises may have been observed on 7/6/26, but it remains unclear if the nurse was notified of the bruises at that time. As a result, the facility is unable to substantiate abuse. Counselling was provided to the aide and nurse to ensure that notification and documentation of any injury of unknown origin need to be completed timely and that the DON an Administrator need to be notified immediately. Surveyor notes the facility's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was submitted on 7/11/26 when the injury of unknown origin was initially identified by staff on 7/6/26. Once the injury of unknown origin was identified on 7/11/26 by a different staff member, it was reported to Nursing Home Administrator (NHA)-A. Surveyor noted the report was submitted 6 days late and should have been reported on 7/6/26 when the injury was initially identified. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/26 at 2:05 PM, Surveyor spoke with NHA-A and Director of Nursing (DON)-B and asked what the expectation for staff is to report an injury of unknown origin and NHA-A stated, immediately upon knowledge to NHA-A and/or DON-B. Surveyor let NHA-A and DON-B know that since staff knew of the bruising on 7/6/26 and it was not discovered by another staff member and reported on their discovery on 7/11/26 that this was a concern. NHA-A acknowledged this was a concern and NHA-A stated that this is why they educated staff on reporting any injuries of unknown origin immediately.		

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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 and record review, the facility did not ensure an alleged violation of mistreatment, including injuries of unknown source, was thoroughly investigated for 2 of 3 (R1, R43) residents reviewed for injuries of unknown origin from a sample of 12 residents. R1 was found by a family member with bruising and swelling of the left ankle. The facility did not investigate the injury of unknown origin. R43 was found with bruising to the forehead. The facility did not investigate the injury of unknown origin or report an investigation. Findings include: The facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property with approval date 8/28/17 and review date 2/11/26 documents: . Investigation of injuries of unknown origin or suspicious injuries: must be immediately investigated to rule out abuse: . injuries include, but are not limited to, bruising of the inner thigh, chest, face and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma. if an incident or allegation is considered reportable, the Executive Director or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within five (5) working days. Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including immediate or 24 hour reporting to the State Survey Agency, law enforcement and the follow up report to the State Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 1) R1 was admitted to the facility on [DATE] with diagnoses including generalized anxiety disorder, major depressive disorder, anemia, and unspecified dementia. R1 had an activated power of attorney (POA) for healthcare decisions. On 7/20/26 at 1:18 PM, Surveyor spoke with R1's POA via phone call who stated R1 has had quite a few falls since being at the facility and the facility stated there were no injuries, however, when they came to visit R1 on 7/14/26, they noticed R1's foot was swollen and bruised. R1's nursing progress note dated 7/13/26 documented an unwitnessed fall at 6:45 AM, R1 was found on the floor mat in front of the bed on knees, no injuries noted. Surveyor reviewed R1's electronic health record (EHR) and located an x-ray report dated 7/14/26 which documented the following: left foot x-ray, no acute findings . left ankle x-ray, no acute findings, soft tissue swelling noted around the ankle. Surveyor was unable to locate any nursing progress notes documenting bruising and swelling of R1's (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left foot or ankle on 7/14/26. R1's skin only evaluation dated 7/14/26 documented skin color within normal limits (WNL), no current skin issues. R1's skin monitoring: comprehensive shower review document dated 7/14/26 documented no new skin issues noted. Surveyor notes both the skin only evaluation and skin monitoring document were completed and signed by Licensed Practical Nurse (LPN)-F. On 7/22/26 at 8:30 AM, Surveyor interviewed LPN-F who stated when they assessed R1's skin on 7/14/26, they did not see any bruising or swelling, and R1 has never had any bruising or swelling on the left ankle. LPN-F did not recall R1 ever getting an x-ray on the left foot or ankle on 7/14/26. On 7/21/26 at 3:01 PM, Surveyor requested any investigation the facility completed for R1's left foot and ankle bruising and swelling on 7/14/26 from Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Clinical Nurse Consultant (CNC)-C. No additional information was provided to Surveyor at that time. On 7/22/26 at 2:04 PM, DON-B informed Surveyor that no investigation was found for R1's left ankle bruising and swelling on 7/14/26. On 7/23/26 at 12:21 PM, Surveyor interviewed NHA-A, who stated NHA-A is made aware of any potential injuries of unknown origin from the DON or assistant DON, who are told of any concerns by floor nurses and floor staff. NHA-A stated the facility would quickly determine if there were a reasonable cause for a resident's injury, and if the facility cannot determine a reasonable cause, they would investigate the injury as an unknown source. Surveyor shared concern with NHA-A that R1 developed bruising and swelling to the left ankle and foot on 7/14/26, but the facility did not investigate the injury. NHA-A stated they believed R1's bruising was a result of a fall the day prior, but the facility did not have any documentation that R1 had injuries or skin abnormalities on 7/13/26 or 7/14/26, so no investigation was completed. 2) R43 was admitted to the facility on [DATE] with diagnosis that included Dementia and Anxiety. The most recent quarterly MDS (Minimum Data Set), dated 5/22/26, documents R43 has a BIMS (brief interview for mental status) score of 6, indicating severe cognitive impairment. R43 is also assessed to have 1 fall since admission without injury and no noted behaviors. Nursing note dated 6/11/26 at 5:34 AM, Skin Evaluation: Skin warm & dry skin color WNL (within normal limits), mucous membranes moist, turgor normal. [R43] has current skin issues. Skin Issue: Bruising. Skin issue location: left eye / forehead Length: 2cm (centimeters) x (by) 2cm Tissue: Painful. Note / Notification / Education: Skin note: RN(Registered Nurse)- [I] entered R43's room to do assessment, while doing vital signs , RN- [I] noticed [R43] in bed awake, [R43] had no O2(oxygen) in place , RN- [I] placed O2 on [R43] at 3L (liters) N/C (nasal cannula) , POX (pulse (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oximetry) - 91% , resp (respirations)- 20 , no SOB (shortness of breath) - bilateral lungs clear , RN-[I] changed [R43's] brief with skin cares, provided fluids, during assessment RN-[I] noted a large bruise / discoloration of yellow / blueish / green to left facial area and forehead with 2cm x 2cm hematoma - no O/A (open area) visible , [R43] can't recall if she fell today. On Jun 09, 2026 &ndash; [R43] did not have any facial bruising or discoloration during NOC (night shift) shift between 2200pm (10:00 PM) - 06am (6:00 AM). Nurse Practitioner- [H] made aware via text message, on call Supervisor made aware via text message, Hospice made aware at 4:00 AM left message, VSS (vital signs stable), neuro. (neurological) check x2 - wnl, PRN (as needed) meds (medication) effective for comfort, bed placed in low position with soft touch call light. On 7/22/26 at 12:15 PM, Surveyor interviewed Director of Nursing- B regarding R43's left facial and forehead bruising and hematoma. Surveyor asked if an investigation had been conducted and DON- B stated she was not in the facility at this time and would need to check into concern further. Surveyor asked DON- B if this injury should have been investigated as an injury as an injury of unknown source. DON- B replied yes, it should have been further investigated. On 7/22/26 at 12:45 PM, Surveyor interviewed RN Nurse Supervisor-D regarding R43's bruising that was discovered by RN- I on 6/11/26. RN Supervisor-D provided Surveyor with documentation regarding R43's fall on 6/7/26. The incident description documents R43 had an unwitnessed fall from the wheelchair to the floor. R43 denied pain other than the raised bump on the left side of her forehead about 5 centimeters by 4 centimeters. Ice was applied. Documented injuries reported for this fall was a bruise to the top of the scalp. Surveyor reviewed the comparison between the injuries noted from the fall on 6/7/26 and the injuries noted by staff on 6/11/26. Surveyor noted staff worked 6/9/26 and the injuries were not present. RN Supervisor- D stated she recalls talking about the fall 6/7/26 but did not have any additional information as to why a further investigation was not completed. 07/23/2026 9:24 AM Surveyor left a voicemail message for RN-I to return call to discuss R43's bruises that were discovered on 6/11/26. RN- I is no longer employed by the facility and did not return Surveyors phone call. As of the time of exit on 7/23/26, the facility was unable to provide additional information as to why R43's bruising to the left eye and forehead was not further investigated as an injury of unknown source.		

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NAME OF PROVIDER OR SUPPLIER Lindengrove Menomonee Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on interview and record review the facility did not ensure 3 (R56, R4 and R1) of 3 residents received necessary care and treatment. On 5/28/26 R56 had physician orders from a nephrology consult for daily weights and applying Sequential Compression Device (SCD) for edema. The facility did not obtain daily weights and SCD to monitor. On 12/30/25 R4 sustained an unwitnessed fall. The fall investigation documents neuro (neurological) checks to be conducted. The facility had no evidence neuro checks were completed. On 7/13/26 R1 sustained an unwitnessed fall. The fall investigation documents neuro (neurological) checks to be conducted. The facility had no evidence neuro checks were completed. Findings include: 1.) R56 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure, congestive heart failure, type 2 diabetes and chronic kidney disease stage 4. The admission minimum data set (MDS) dated [DATE] documents R56 is cognitively intact. On 5/28/26 R 56's nephrology consultation form documents the following orders: discontinue (d/c) Lasix, start bumex 2 milligram (mg) twice a day (BID), daily weights, if not losing weight to call nephrology and if possible, apply SCD (Sequential Compression Device) for edema. Surveyor reviewed R56's medication administration record (MAR) and treatment administration record (TAR). The MAR documents Lasix was d/c and bumex was ordered. There is no documentation of daily weights or SCD being ordered. On 5/30/26 R56 was discharged home with home health services. The discharge summary does not document if SCD was ordered for R56 for home use. On 7/23/26 at 9:35 a.m. Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked who is responsible for following through on the nephrology consult orders. DON-B stated the nurse that receives that consult is responsible. Surveyor explained the order for daily weights were not completed. Surveyor also explained SCD were not ordered. DON stated the facility does not order SCD. Surveyor asked if the nephrology office were made aware of SCD not ordered and if there were other devices or ways to help with R56 edema. Surveyor also asked if SCD were ordered as part of the discharge home orders. DON-B stated she was not sure and would look into it. On 7/23/26 at 11:02 a.m. DON-B explained the facility did not order SCD and did not follow up with nephrology because the order said if possible. DON-B stated R56 was sent home with home physical and occupation therapy, and they could assess R56's need for SCD and whether insurance would (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cover it. Surveyor notes here is no documentation the need for SCD for edema was communicated to the home health agency. 2.) R4 was admitted to the facility on [DATE] with diagnoses of vascular dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. The quarterly minimum data set (MDS) dated [DATE] documents severe cognitive impairments and needs moderate assistance for bed mobility and dependent on staff for transfers. On 12/30/25 R4 had an unwitnessed fall. The fall investigation documents R4 was self-transferring from the wheelchair to the toilet. R4 was observed on his buttocks on the floor in the bathroom. The fall investigation documents, because R4 had an unwitnessed fall neuro (neurological) checks were started. On 7/22/26 at 9:30 a.m., Surveyor spoke with Director of Nursing (DON)-B and Clinical Nurse Consultant (CNC)-C. Surveyor asked to see the neuro checks that were completed for R4 related to the 12/30/25 fall. On 7/22/26 at 12:00 p.m., CNC-C and DON-B explained they are unable to locate any further information related to R4's fall and neuro checks. 3.) R1 was admitted to the facility on [DATE], with diagnoses including generalized anxiety disorder, unspecified dementia, and major depressive disorder. R1's Annual MDS assessment dated [DATE] documented R1 had a Brief Interview of Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. R1 had an activated healthcare power of attorney (POA). R1's MDS documented 2 or more falls since admission with no injury. R1's Care Area Assessment (CAA) for falls dated 6/30/26 documented a fall score of 21 indicates fall risk, fall history, gets up without assistance of call light, continue assistance to safely transition surfaces, encourage and remind to call for assist, proceed to care plan. R1's nursing progress note dated 7/13/26 documented an unwitnessed fall at 6:45 AM, found on knees on the floor mat in front of bed, no injuries noted, vital signs stable. On 7/22/26, Surveyor requested R1's fall investigation with evidence of neurochecks completed by the facility on 7/13/26 from Director of Nursing (DON)-B. On 7/22/26 at 2:04 PM, DON-B and Clinical Nurse Consultant (CNC)-C informed Surveyor they could not find an investigation for R1's fall on 7/13/26 with evidence that neurochecks were completed. CNC-C stated neurochecks should have been completed since it was an unwitnessed fall.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R39) of 1 resident was free of significant medication errors from a sample of 12 residents. R39 received a different resident's medications on 6/10/26. R39 was prescribed Valbenazine Tosylate for Tardive Dyskinesia without a documented diagnosis of Tardive Dyskinesia or other documented indication to receive Valbenazine Tosylate. R39 was administered 32 doses of Valbenazine Tosylate 60 milligrams (mg) between the dates of 6/16/26 and 7/21/26. Findings include: The facility policy titled Pharmacy Services for Nursing Facilities dated 5/2018 documents: .Administration . if a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification. This interaction with the pharmacy and/or prescriber and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate. the person who prepares the dose for administration is the person who administers the dose . residents are identified before medication is administered using two methods of identification. Methods of identification include: checking photograph attached to medical record, calling resident by name, having the resident verify his/her last name, if necessary, verifying resident identification with other facility personnel. R39 was admitted to the facility on [DATE] with diagnoses including depression, hypertension, generalized anxiety disorder, hypothyroidism, orthostatic hypotension, Type 2 Diabetes Mellitus, and unspecified dementia. R39's Quarterly Minimum Data Set (MDS) dated [DATE] documented R39 had a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. R39 had an activated power of attorney (POA) for healthcare decisions. Surveyor reviewed R39's electronic health record (EHR) and located a nursing progress note dated 6/10/26 at 22:42 (10:42 pm) written by Registered Nurse (RN)-E that documented at 1800 (6:00 pm) resident was mistakenly given meds (medications) meant for another resident. R39 was noted to spit meds out onto clothing and meds were accounted for except for one of the APAP (acetaminophen). Nurse Practitioner (NP) was called and notified. Orders received for blood pressures every 2 hours from 1800 (6:00PM) to midnight and then once more between 4:00 am and 5:00 am, as there was a blood pressure med with the meds spit out. On 7/22/26, Surveyor interviewed RN-E, who confirmed RN-E administered a different resident's medications to R39 on 6/10/26. RN-E stated R39 spit the medications out right away, but some of them were melted from being in R39's mouth. Surveyor asked RN-E if the facility followed up with RN-E regarding the medication error to obtain a statement or provide any education, and RN-E replied no. RN-E stated R39 was monitored after the event and there were not any adverse outcomes. On 7/21/26 at 3:01 PM, Surveyor asked Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Clinical Nurse Consultant (CNC)-C if there was any further information or investigation regarding R39 being administered a different resident's medications on 6/10/26. DON-B stated they would look into the matter, but no additional information was provided. On 7/21/26, Surveyor reviewed R39's current physician's orders and located an order for Valbenazine Tosylate Oral Capsule 60 mg, give 1 capsule by mouth in the morning for Tardive Dyskinesia with a start date of 6/16/26 and noted the order was still active. Surveyor reviewed R39's diagnoses and did not locate a medical diagnosis of Tardive Dyskinesia. R39's Medication Administration Record (MAR) for June 2026 and July 2026 documented R39 was administered Valbenazine Tosylate Oral Capsule 60 mg once a day on the following dates: 6/16/26, 6/17/26, 6/18/26, 6/19/26, 6/20/26, 6/21/26, 6/22/26, 6/23/26, 6/24/26, (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/25/26, 6/26/26, 6/27/26, 6/28/26, 6/29/26, 6/30/26, 7/2/26, 7/3/26, 7/7/26, 7/8/26, 7/9/26, 7/10/26, 7/11/26, 7/12/26, 7/13/26, 7/14/26, 7/15/26, 7/16/26, 7/17/26, 7/18/26, 7/19/26, 7/20/26, 7/21/26, totaling 32 doses administered.R39's Psychoactive Medication and Behavior Committee note dated 6/10/26 documented medications of Memantine HCl Tablet 5 mg for dementia and Sertraline HCl Tablet 25 mg for depression. The note did not document any adverse side effects, any monitoring for adverse side effects, or any interdisciplinary team (IDT) recommendations to include updating care plan, risk/benefit, and gradual dose reduction (GDR) request.R39's Abnormal Involuntary Movement Scale (AIMS) Evaluation dated 6/15/26 documented a score of 1, with muscles of facial expression: e.g. movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing scored as 1. minimal. The evaluation documented the higher the score (0-28), the greater the impact of observed movements on resident.On 7/21/26 at 1:59 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D, who stated the monthly behavior committee meetings consist of ADON-D, the pharmacist, the psychiatrist, and one of the social workers at the facility. Surveyor asked ADON-D why R39 was started on Valbenazine Tosylate on 6/16/26, and ADON-D stated it may have been discussed at the behavior committee meeting on 6/10/26, but ADON-D had just started at the facility around that time and could not recall specifically if it was discussed or not. ADON-D confirmed the order was put into the system by ADON-D, but they could not state why the order was started.On 7/21/26 at 2:18 PM, Surveyor interviewed Life Coach (LC)-P, who confirmed they attend the behavioral committee meetings on a monthly basis including R39's meeting on 6/10/26. LC-P reviewed their notes from R39's meeting on 6/10/26 and did not locate any documentation regarding Valbenazine Tosylate or R39 having Tardive Dyskinesia. LC-P stated they would reach out to the pharmacist and psychiatrist and get back to Surveyor.On 7/21/26 at 2:57 PM, LC-P stated the pharmacist and psychiatrist spoke with LC-P on the phone and could not locate any documentation on why R39 was started on Valbenazine Tosylate. LC-P provided Surveyor with an email printout dated 7/21/26 at 2:49 PM, which documented the pharmacist had no notes from the meeting regarding R39 being on Valbenazine.On 7/22/26 at 2:02 PM, Surveyor shared concern with DON-B and CNC-C that R39 received a different resident's medications on 6/10/26, and R39 was administered Valbenazine Tosylate 6/16/26-7/21/26 without evidence of an indication of use. CNC-C stated no one really knows why R39 was started on Valbenazine. CNC-C stated a lot of verbal orders are discussed at the monthly behavioral meetings and they think the medication may have been intended for a different resident. CNC-C stated the medication was discontinued on 7/21/26 and the facility is still investigating what happened. Surveyor was provided with a medication error document dated 7/21/26 at 14:00 (2:00 pm) written by ADON-D, which documented medication reviewed and noted resident was started on Valbenazine due to medication transcription error, medication had been ordered for another resident.		