| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525422 | A. Building<br>B. Wing | 03/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lindengrove Waukesha | 425 N University Dr<br>Waukesha, WI 53188 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411<br><br>Based on record review and staff interview, the facility failed to ensure one (Resident (R)8) of 11 residents reviewed for code status was accurately documented throughout the medical record. This had the potential for the resident and/or responsible party's wishes not to be honored.<br><br>Findings include:<br><br>Review of R8's Face Sheet located in the electronic medical record (EMR) revealed R8 was admitted to the facility on [DATE] under hospice care. R8 was noted to be a Full Code status.<br><br>Review of R8's Plan of Care (POC) located in the Plan of Care tab in the EMR revealed R8 had a terminal prognosis and was under hospice care. R8's living will was to be reviewed and ensured it was followed, family is to be involved in the discussion.<br><br>Review of the hospice form provided by the Administrator revealed R8 had been a Do not Resuscitate (DNR) since 10/02/22.<br><br>During an interview on 03/25/24 at 1:38 PM with Family Member (FM) of R8 revealed they were walking into R8's room and found him nonresponsive, without a pulse and respiration. The FM revealed they notified the nurse on duty and let them know he was a DNR. The Registered Nurse (RN) replied that his EMR showed he was a Full Code. The FM revealed the RN had her sign another DNR form.<br><br>During an interview on 03/25/24 at 3:46 PM with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON), the Administrator stated, remembering the situation of the code status for R8, it was an agency nurse, and she was following what was in the chart. I see in my records that R8 has been a DNR since 10/02/22. The Administrator confirmed that part of R8's EMR showed the resident was a Full Code. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525422 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/27/2024 |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728<br><br>Based on record review, staff interview, and review of facility policy, the facility failed to ensure that a resident who was admitted without a pressure injury was properly assessed and monitored to prevent the development of a pressure injury for one resident (Resident (R) 5) out of three residents reviewed for pressure injuries. This resulted in the development of a facility acquired, stage 3 pressure injury.<br><br>Findings include:<br><br>Review of the facility's policy titled, Pressure Injury-Prevention and Managing Skin Integrity dated 08/10/2023 indicated, 3. Skin Checks: a. Skin checks will be done upon admission, readmission or as clinically indicated. b. While providing routine care, a licensed nurse is to monitor the skin condition of each individual weekly and document the Skin Check in the medical record.<br><br>Review of the R5's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, diabetes mellitus, chronic kidney disease, and transient ischemic attack (stroke).<br><br>Review of R5's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 01/23/24 revealed the resident was assessed with a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating the resident was severely cognitively impaired. She was identified as being at risk for developing pressure injuries, however, did not have any pressure injuries on admission.<br><br>Review of the Braden Scale for Predicting Pressure Ulcer Risk located under the Miscellaneous tab, completed on 01/16/24, the day of admission, revealed R5 scored 20 which indicated no risk of developing a pressure injury.<br><br>Review of R5's care plans indicate despite risk for pressure injuries, there were no interventions to prevent the development of a pressure injury.<br><br>Review of the Initial Wound Evaluation and Management Summary dated 01/31/24 completed by the wound care specialist physician revealed R5 was evaluated and treated for a Stage 3 pressure injury to her right buttock measuring 0.5 centimeters (cm) x 0.5 cm x 0.2 cm in depth with 100% granulation tissue. Review of the skin evaluation on this date indicates the wound is greater that 7 days in duration. Additional information from the wound physician was not available after the initial evaluation. The resident was transferred to the hospital for another reason and did not return to the facility.<br><br>Review of the facility skin check/bath sheets indicate staff were either not completing this review to monitor R5's skin.<br><br>Review of the Progress Notes located in the Progress Notes tab in the EMR, did not reveal any indication or identification the resident had any pressure injuries or skin condition in the physician or nurse practitioner notes from admission through the last entry of 01/31/24.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Lindengrove Waukesha | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 N University Dr Waukesha, WI 53188 | |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R5's EMR revealed no evidence of any supporting documentation of when the wound was initially identified or a description of the wound once identified. The facility was unable to provide any additional information from the medical record or from staff working the two weeks the resident was in the facility regarding the development of the resident's pressure injury. There were no skin assessments from the time of admission until the Initial Wound Evaluation and Management Summary dated 01/31/24.<br><br>During an interview with Licensed Practical Nurse (LPN) 2 on 03/26/24 at 3:30 PM revealed she worked on the night shift and was not aware R5 had a pressure injury. She never received a report of the resident having any skin concerns.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 03/26/24 at 3:30 PM revealed she was not aware of the pressure injury and would review the medical record for additional information.<br><br>During an interview with the Administrator on 03/27/24 at 1:30 PM, confirmed there was no additional information available prior to when the wound was first identified. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728<br><br>Based on record review, staff interview, and facility policy review, the facility failed to complete a thorough investigation of a fall for one (Resident (R) 5) of three sampled residents reviewed for falls. This had the potential for additional falls and potential injuries to the resident.<br><br>Findings include:<br><br>Review of the facility's policy titled, Falls dated 06/13/23, indicated 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 .3. Administrative Review a. The Interdisciplinary Team (IDT) will review Fall Incident report and utilize root cause analysis to make further recommendations.<br><br>Review of the R5's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, unsteadiness on feet, and muscle weakness.<br><br>Review of R5's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 01/23/24 revealed the resident was assessed with a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating the resident was severely cognitively impaired. She required moderate assistance with most activities of daily living, required supervision for ambulation short distances and had not had any falls prior to admission or since her admission of 01/16/24.<br><br>Review of R5's Progress Note located in the EMR under the Progress Note tab, dated 01/19/24, revealed, the resident was found sitting on the floor in her room. She was not wearing any socks or shoes on her feet. When asked what happened, she said she had slipped down onto the floor. The fall was unwitnessed. Resident denies pain. No injury noted. Numerous phone calls to interview the nurse were unsuccessful.<br><br>Review of the Incident Report provided by the Administration revealed that the date of R5's fall on 01/19/24 or the resident's name did not appear on the report during the time she resided in the facility.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 03/27/24 at 8:30 AM, she indicated she had made numerous calls and texts to the nurse that was on duty but had not heard back. At this time, she did not have any additional information.<br><br>During an interview with the Administrator on 03/27/24 at 9:30 AM, she confirmed she did not have any additional information of an investigation of the fall by the risk committee regarding R5's fall on 01/19/24. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728<br><br>Based on record review, observation, interview, and policy review, the facility failed to provide incontinence care in a timely manner for one of three sampled residents (Resident (R) 3) reviewed for incontinence care. The failure of the facility to check and change the resident after an incontinent episode put the resident at risk for developing skin issues and potentially an urinary tract infection (UTI).<br><br>Findings include:<br><br>Review of the facility's undated policy titled, Standard ADL (Activities of Daily Living) Protocol revealed, ADL's: Dressing, grooming, eating, toileting, bathing and personal hygiene. Problem: Individual requires assistance with Activities of Daily Living (ADL's), Certified Nursing Assistant (CNA): Toileting every 2 to 3 hours or per individual preference .Provide incontinence care as needed.<br><br>Review of R3's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses of right hemiplegia (paralysis), Alzheimer's disease, and dementia.<br><br>Review of R3's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/01/24 and located under the MDS tab of the EMR, revealed the resident was assessed with a BIMS (Brief Interview for Mental Status) score of seven out of 15 indicating the resident was moderately cognitively impaired. The resident required maximum assistance for toileting and was frequently incontinent of bowel and bladder.<br><br>Review of R3's Care Plan located in the EMR under the Care Plan tab indicated the resident had bladder incontinence related to activity intolerance, dementia, and impaired mobility with interventions to clean after every incontinence episode and monitor for signs of urinary tract infection.<br><br>During an observation on 03/25/24 at 12:40 PM, R3 was eating his lunch. A puddle of liquid was noted on the floor under the resident's wheelchair. As he pushed his wheelchair away from the table, the front of his pants and inner thighs were observed to be wet. On the way out of the dining room, the resident stated, I had an accident.<br><br>During an observation on 03/25/24 at 1:00 PM revealed R3 sitting in his wheelchair in his room visiting his wife. His pants remained wet in the same area.<br><br>During another observation on 03/25/24 at 1:45 PM revealed R3 and his wife remained in his room and he continued to have on the same wet pants which appeared to be drying.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 03/25/24 at 2:10 PM, R3 remained in his wheelchair in his room and was observed to have had another incontinent episode. His pants were saturated with urine. At this time, his wife pressed his call bell and asked staff to change the resident. Certified Nursing Assistant (CNA) 1, entered the resident's room, took the resident in his wheelchair to the bathroom and provided incontinence care. The resident's brief was saturated with urine, his pants and the bottom of his shirt were saturated with urine. The cushion in the wheelchair was also wet with visible urine. A strong smell of urine was noted when the brief was removed.<br><br>During an interview with CNA1 on 03/25/24 at 2:40 PM, she stated the last time she had changed R3 was between 10:00-10:30 AM earlier that morning but had not checked him for incontinence since. She stated he should be checked for incontinence every two to three hours but she was the only CNA here today on the unit all day.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 03/27/24, at 8:30 AM she confirmed the resident should be checked for incontinence every two hours. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728<br><br>Based on observation, staff interviews, and review of the facility's policy, the facility failed to ensure staff performed hand hygiene during incontinence care for one resident (Resident (R) 3) of one observed during from a sample of 11 residents. This had the potential for infection control not being maintained.<br><br>Findings include:<br><br>Review of the facility's policy titled, Hand Hygiene dated 09/20/23, revealed, The organization will promote clean hands as the single most important factor in preventing the spread of pathogens, antibiotic resistance, and incidence of infections. Specific indications for hand hygiene .3. Before moving from work on a soiled body site to a clean body site on the same patient . 6. Immediately after glove removal.<br><br>Review of R3's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses of right hemiplegia (paralysis), Alzheimer's disease, and dementia.<br><br>Review of R3's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/01/24 and located under the MDS tab of the EMR, revealed the resident was assessed with a BIMS (Brief Interview for Mental Status) score of seven out of 15 indicating the resident was moderately cognitively impaired. The resident required maximum assistance for toileting and was frequently incontinent of bowel and bladder.<br><br>Review of R3's Care Plan located in the EMR under the Care Plan tab indicated the resident had bladder incontinence related to activity intolerance, dementia, and impaired mobility with interventions to clean after every incontinence episode and monitor for signs of urinary tract infection.<br><br>During an observation on 03/25/24 at 2:15 PM revealed Certified Nursing Assistant (CNA)1 provided incontinence care to R3. She donned (put on) a pair of gloves, removed the resident's soiled pants and brief that were saturated with urine. The resident's soiled shirt was removed and wheelchair cushion was cleaned of urine. Using the same gloves, CNA 1 cleaned the resident's perineal area, applied a clean brief and clothing for the resident. After cleaning the resident, she rolled the resident from the bathroom to the side of the bed and changed his oxygen tubing from the tank on the back of his chair to the concentrator next to his bed. With the same gloves, she touched the prongs of the nasal cannula to check for air before placing them back in the resident's nose. After checking the oxygen cannula, CNA 1 removed her gloves and left the room.<br><br>During an interview with CNA 1, immediately after the observation, she stated that she realized that she did not remove her soiled gloves after removing the resident's soiled clothing and before putting on a clean brief.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 03/27/24 at 8:30 AM, she confirmed the CNA should have changed her gloves between the soiled brief and clean brief. |