STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525422	A. Building B. Wing	05/29/2025

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

(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** 42440 Based on record review, interview, and facility policy review, the facility failed to accurately transcribe medication orders to ensure correct administration of prednisone (oral steroid) and failed to notify the provider of elevated blood glucose levels for one of three residents (Resident (R) 2) reviewed for blood sugars out of 10 sampled residents. This failure had the potential to result in withdrawal symptoms from not tapering the prednisone and in adverse health effects from not managing elevated blood glucose levels. Findings include: Review of the facility's policy titled, Medication Administration-General Guidelines, revised 12/19, revealed Medications are administered as prescribed . Review of the facility's undated policy titled, Standard Diabetes Mellitus Protocol revealed . 2) blood sugars to be within parameters as determined by the physician orders 3) exhibit no hypo/hyperglycemic episodes . update physician and responsible party as needed . Review of R2's Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] following a hospital stay. R2 had diagnoses including diabetes mellitus, spinal stenosis, and sciatica. Review of R2's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/25/24 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R2 was cognitively intact. Review of R2's Care Plan located in the EMR under the Care Plan tab, documented The resident has acute/chronic pain, initiated on 09/26/24 with an intervention, Administer medication per MD [medical doctor] orders. Review of R2's hospital Discharge Summary, dated 10/03/24 and located in the Documents tab of the EMR, revealed R2 had low back pain, sciatic pain, and spinal stenosis. It included an order to start prednisone 20 milligrams (mg) two tablets for three days, then 1.5 tablets for three days, then one tablet for three days, then 0.5 tablets for three days. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/25 at 10:43 AM, R2 stated she went out to the hospital and returned on a prednisone taper. There were days they wouldn't give it to me and days they gave me the incorrect number of tablets. Review of R2's Orders tab of the EMR, revealed orders for prednisone, reflected in the Medication Administration Record (MAR) dated 10/24 as: -20 mg, give two tablets for three days from 10/04/24 to 10/06/24, documented as administered. -20 mg, give two tablets for three days, with a start date and discontinued date of 10/07/24, documented as administered on 10/07/24. -20 mg, give two tablets from 10/10/24 to 10/12/24, documented as administered on 10/10/24 and as refused on 10/11/24 and 10/12/24. -20 mg, give 1.5 tablets from 10/13/24 to 10/15/24, documented as administered on 10/13/24 and as refused on 10/14/24 and 10/15/24. -20 mg, give one tablet from 10/16/24 to 10/18/24, documented as refused. -20 mg, give 0.5 tablets on 10/19/24 and 10/20/24, documented as refused. During an interview on 05/29/25 at 2:45 PM, the Director of Nursing (DON) reported orders for new admissions were put into the EMR based on the hospital discharge summary by an off-site informatics department. The orders went into a queue for two onsite nurses to verify. During an interview on 05/29/25 at 2:50 PM, the DON reported R2's prednisone orders on the MAR did not reflect what was ordered by the hospital. 2. Review of R2's Care Plan located in the EMR under the Care Plan tab, documented The resident has diabetes mellitus, initiated on 09/18/24 with an intervention, blood sugar monitoring as ordered by doctor. Review of R2's Orders tab of the EMR revealed an order, dated 10/03/24, for blood glucose tests four times daily, without parameters as to when to notify the provider. Lispro insulin was ordered from 10/03/24 to 10/07/24 in the afternoon and from 10/03/24 to 10/06/24 in the evening with no parameters provided as to when to notify the provider. Starting on 10/07/24 in the evening the sliding scale lispro insulin orders were clarified and also updated to include if blood sugar > 400 call provider. Review of R2's October 2024 MAR located under the Orders tab of the EMR, revealed two recorded blood glucose levels over 400. There were readings of 444 on 10/06/24 at 7:00 PM and 418 on 10/07/24 at 3:00 PM. Review of the Prog Notes tab of the EMR revealed a Nurse's Note, dated 10/06/24 at 7:38 PM: Resident is being monitored for hyperglycemia [high blood glucose]. No issues noted this shift. Resident has denied any s/s [signs/symptoms] related to hyperglycemia . There was no documentation of elevated blood glucose levels reported to the provider on 10/06/24 or 10/07/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/25 at 10:43 AM, R2 stated there were two nights she went to bed with a blood glucose over 400 for which staff did nothing. R2 received no additional insulin or a recheck of her blood glucose. During an interview on 05/28/25 at 11:32 AM, Registered Nurse (RN) 2 stated nurses were to notify the physician of elevated blood glucose levels based on the parameters in their orders. If there were no parameters, RN2 called the provider to obtain them. During an interview on 05/29/25 at 10:45 AM, Medication Administration Assistant (CMA) 1, who recorded the blood glucose level of 444 on 10/06/24, stated she could not recall that specific reading, but she would have reported a reading that high to the nurse immediately. During an interview on 05/29/25 at 11:40 AM, the Assistant Director of Nursing (ADON) reported that the facility reviewed new admissions with the nurse practitioner who determined orders specific to the resident on when to notify a provider of a blood glucose reading. During an interview on 05/29/25 at 3:00 PM, RN1 stated she went off the parameters in the order as to when to notify a provider of an elevated blood glucose reading. RN1 stated if there were no parameters, she notified the provider if a blood glucose reading was greater than 400. RN1 was unable to recall R2's reading of 418 on 10/07/24 but felt she would have notified the provider and documented the notification to the provider. During an interview on 05/29/25 at 4:05 PM, the DON reported she expected the provider to be notified of blood glucose readings greater than 400, or per the ordered parameters if they were different. The DON stated nurses were expected to document the notification to the provider and the provider's response in the EMR. The DON was unable to find evidence that the provider had been notified of the elevated blood glucose levels on 10/06/24 and 10/07/24.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and facility policy review, the facility failed to obtain wound treatment orders timely when a pressure injury was identified for two of three residents (Resident (R) 4 and R1) reviewed for pressure injury out of 10 sample residents. This had the potential for residents' pressure injuries to decline. Findings include: Review of the facility's policy titled, Pressure Injury Prevention and Managing Skin Integrity, dated 02/08/17, revealed: The care and intervention for any skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown. 1. There will be collaboration with the interdisciplinary team [IDT] regarding the presence of breakdown and the intervention plan . Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. Registered Nurse [RN] or designee will: i. conduct weekly skin evaluation, ii. Update the [primary care provider] with any decline in wound appearance, or as necessary, iii. Update the care plan with any new interventions as applicable . 1. Review of R4's Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] and had diagnoses including encounter for surgical aftercare following surgery on the digestive system and muscle weakness. Review of R4's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/24/25 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The assessment revealed R4 was at risk for the development of pressure injuries but had none. Review of R4's eINTERACT Change in Condition Evaluation, dated 03/30/25 and located in the Assessments tab of the EMR, revealed R4 had a new mixed stage 1-2 pressure injury to her right gluteal fold. Located during cares. Cleansed with wound cleanser MD [medical doctor] notified through [facility's messaging system]. Orders received. Review of R4's Orders tab of the EMR, revealed no treatment orders for a pressure injury during her stay. No new orders were placed on 03/30/25, and R4 discharged on [DATE] to the hospital without orders for wound care. Review of R4's Care Plan located in the Care Plan tab of the EMR revealed R4 admitted with redness to her groin, initiated 03/18/25 with a goal of maintaining or developing clean and intact skin. The Care Plan did not address the pressure injury until 04/09/25 when it was added to the dietary focus. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/25 at 11:32 AM, Registered Nurse (RN) 2 stated if a resident was observed to have a new wound, the nurse gathered data and documented the information on a skin assessment. RN2 stated then the nurse obtained orders from the provider based on the observation and assessment. We have to document in the system what the wound is, make notifications to the provider, ensure we have orders, and get the resident on the weekly wound rounds list. During an interview on 05/28/25 at 11:40 AM, Assistant Director of Nursing (ADON) reviewed R4's documentation and reported she was unable to find any treatment orders for the pressure injury. During an interview on 05/29/25 at 1:40 PM, the Director of Nursing (DON) reported that when a resident developed a new pressure injury, it was expected that nursing would document it in risk management, which the DON checked daily. The DON stated R4's pressure injury was not put into risk management, and the order the nurse received was never documented. During an interview on 05/29/25 at 2:45 PM, the ADON reported she was doing off-site training when R4 was observed with the new pressure injury, so no one reported it to her. ADON stated the nurse who identified the pressure injury put the treatment on the 24-hour board (the system the facility used for residents who need additional monitoring) but did not put an order in the EMR for staff to refer to and sign off when completed. The ADON stated the order received was for mepilex (a wound dressing). 2. Review of R1's Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including diabetes and vascular dementia. Review of R1's quarterly MDS with an ARD of 03/04/25 and located in the EMR under the MDS tab, revealed a BIMS score of six out of 15, indicating severely impaired cognition. R1 had a stage three pressure injury with pressure injury care. Review of R1's Care Plan located in the Care Plan tab of the EMR, revealed The resident has a stage 3 pressure injury to coccyx, initiated on 03/11/25, after Resident admitted with a wound to his coccyx, initiated on 08/26/24 was resolved. Review of R1's Nurse's Note, dated 08/26/24 and located in the Prog Note tab of the EMR, revealed R1 admitted with a surgical incision and coccyx wound with mepilex and wound vac. Review of R1's Nurse's Note, dated 08/28/24 and located in the Prog Note tab of the EMR, revealed R1's wound vac was removed and had been on his surgical wound on his leg and not on his coccyx. Review of R1's Skin Only Evaluation, dated 08/28/24 and located in the Assessments tab of the EMR, revealed R1 had a stage three pressure injury on his coccyx measuring three centimeters (cm) in length by 1. 8 cm in width by 1.2 cm deep. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Medication Administration Records (MARs) and Treatment Administration Records (TARs), dated 08/24 and 09/24 and located in the Orders tab of the EMR, revealed no treatment order for the stage three coccyx pressure injury until 09/09/24, two weeks after R1 was admitted to the facility. On 09/09/24, the order was for skin prep around the wound and a foam adhesive bordered gauze every other day to the coccyx. On 08/26/24, R1 had an order on admission for moisture barrier cream apply to topically topically [sic] every 24 hours as needed for ***nurse to enter diagnosis*** which was not signed off as administered. Review of an Initial Wound Evaluation & Management Summary report by the facility's wound provider, Physician1, dated 09/18/24, and located in the Documents tab of the EMR, revealed the wound provider identified R1's coccyx wound as a stage three pressure injury measuring 0.7 x 1.2 x 0.2 cm. During an interview on 05/28/25 at 8:47 AM, the ADON reported she was the facility's wound nurse and had been for about five to six months. The ADON stated prior to her being in the role of wound nurse, there had not been a wound nurse or system. The ADON stated had tried to assist with the initial assessment of resident's wounds when they were admitted . The ADON stated if the hospital ordered a wound treatment; the facility typically used that order. ADON stated if the hospital provided no orders, or there were concerns with the orders provided, the facility obtained orders from Physician1 or the resident's provider. The ADON confirmed R9 had no treatment orders for his coccyx wound from 08/26/25 until 09/09/25. During a concurrent observation and interview on 05/28/25 at 11:08 AM, Physician1 assessed R1's coccyx wound, and the ADON administered the treatment. Physician1 reported the coccyx wound had been getting better. During an interview on 05/29/25 at 1:40 PM, the DON reported she expected the floor nurse to do a Skin Only assessment or Admission Evaluation when a resident was admitted . Nursing management reviewed those reports the next business day. The DON stated if a resident was admitted to the facility on a Friday or after hours, the floor nurse was expected to reach out to the provider for a treatment order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and facility policy review, the facility failed to have medications available to administer as ordered for two of four residents (Resident (R) 9 and R2) reviewed for medication availability out of 10 sample residents. This had the potential to result in adverse health outcomes. Findings include: Review of the facility's policy titled, Medication Administration - General Guidelines, revised 12/19, revealed: If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), .If electronic MAR [Medication Administration Record] is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR [electronic MAR] system . If [XX consecutive doses] of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response. 1. Review of R9's Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE]. R9 had diagnoses including chronic respiratory failure with hypoxia (low oxygen levels). Review of R9's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/25 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. Review of R9's Orders tab of the EMR, revealed an order for Breztri aerosphere inhaler two puffs twice daily for respiratory treatment, dated 05/14/25. Review of R9's MAR dated 05/25 and located under the Orders tab of the EMR, revealed the Breztri was documented with the code 9, which referred the reviewer to other/see progress notes for the evening doses on 05/21/25, 05/22/25, and 05/24/25. Fourteen of 28 doses from 05/14/25 to 5/28/25 were coded as 16 which indicated med unavailable - pharmacy contacted. Review of R9's eMar- Medication Administration Notes, located under the Prog Notes tab of the EMR, revealed the Breztri inhaler was on order on 05/21/25, 05/22/25, and 05/24/25. During an observation on 05/28/25 at 8:30 AM, Registered Nurse (RN) 3 administered R9's morning medications. The Breztri inhaler was unavailable, and RN3 documented a Progress Note stating, Pharmacy was notified however no inhaler has been received. During an interview on 05/28/25 at 8:40 AM, RN3 stated, I called pharmacy last week. It's a high-cost medication and so needs approval from management. When asked how management approved medications, RN3 stated the pharmacy faxed over a request, which the management needed to sign and return. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/25 at 11:40 AM, the Assistant Director of Nursing (ADON) stated the Director of Nursing (DON) was responsible for authorizing high-cost medications. The ADON stated if she was aware that medications were high cost, she spoke to the nurse practitioner who then spoke to the resident about changing high-cost medications to an alternative medication. ADON reported she was unaware R8's Breztri was unavailable because of the pharmacy needing authorization to send it. During an interview on 05/29/25 at 12:06 PM, Pharmacist1 reported the pharmacy had not sent R8's Breztri inhaler due to waiting on facility authorization due to the cost. The Pharmacist1 stated the pharmacy faxed requests for authorization on 05/14/25 and 05/22/25. During an interview on 05/29/25 at 1:40 PM, the DON reported she communicated with the resident about high-cost medications when the pharmacy sent faxes for authorization. The DON stated she was not notified that R8's Breztri needed authorization. During an interview on 05/29/25 at 2:50 PM, the DON stated she expected if medication was unavailable to administer, staff to check the contingency supply. The DON stated if the medication was not in contingency, staff were expected to call pharmacy and notify nursing management of the reason the medication was not available so they could follow up. 2. Review of R2's Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE]. R2 had diagnoses including chronic obstructive pulmonary disease (COPD) and asthma. Review of R2's admission MDS with an ARD of 09/25/24 and located in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, indicating intact cognition. Review of R2's Orders tab of the EMR, revealed an order for fluticasone-salmeterol (Advair) inhaler twice daily on 09/18/24 and renewed on 10/03/24. Review of R2's MARs, dated 09/24 and 10/25 and located under the Orders tab of the EMR, revealed the Advair inhaler was documented with the code 9, which referred the reviewer to other/see progress notes for the evening doses on 09/18/24 and 09/23/24 and for the day dose on 09/22/24. The 09/21/24 and 10/08/24 morning doses were coded as 16 which indicated med unavailable - pharmacy contacted. There was no documentation to indicate the Advair was administered for the morning doses on 09/23/24 and 10/04/24 or the evening dose on 09/24/24. Review of R2's eMar - Medication Administration Notes, located under the Prog Notes tab of the EMR, revealed the Advair inhaler was Not available, waiting pharmacy on 09/18/24, not available, waiting pharmacy on 09/22/24, and on order on 09/23/24. During an interview on 05/28/25 at 10:43 AM, R2 reported she did not receive her Advair discus twice daily as scheduled consistently through her stay. During an interview on 05/29/25 at 12:06 PM, Pharmacist1 reported R2's Advair inhaler was sent to the facility on [DATE] and again on 10/03/24. Pharmacist1 stated each inhaler provided 60 inhalations, good for 30 days, and so should have been available for all her scheduled doses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/29/25 at 1:40 PM, the DON verified the documentation revealed that R2 had not received doses of the Advair inhaler.