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| 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 01/21/2026 |
| NAME OF PROVIDER OR SUPPLIER Lindengrove Waukesha | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | | |
| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure resident representatives and three of three residents (Resident (R) 1, R9, and R10) reviewed for transfer requirements out of a sample of 10 were provided with written notification of the facility's bed hold policy prior to transfer to the hospital. The facility also failed to submit documentation of the facility discharge notices to representatives of the Office of the State Long-Term Care Ombudsman. By not ensuring information regarding the bed hold process is explained to residents and/or representatives could create distress or confusion related to readmission to the facility due to the facility-initiated discharge. Findings include: 1. Review of R1's admission Record located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted [DATE] and the date of discharge to the hospital was [DATE]. Review of R1's discharge return anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the resident's EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R1's cognition was moderately impaired. Review of R1's Progress Notes dated [DATE] and located under the Prog Note tab of the EMR, revealed, Upon arrival resident was in the room laying on his right side, alert, and noted a cut/bruise and bleeding on the right side of his eyelid. Writer assessed the resident and sent resident to hospital for evaluation. Writer notified power of attorney (POA). Review of an eInteract Transfer Form dated [DATE] and located in R1's EMR under the Assmnts [Assessment] tab revealed Transfer/Discharge Details: Sent to: [name of hospital]. Reason(s) for Transfer: Other. Reason for transfer: Unplanned. Further review of the Transfer form revealed R1's representative was notified of the transfer by Registered Nurse (RN) 1 however, there was no documentation the bed hold process was explained, documentation given to the resident and/or representative of R1, and no documentation of notification to the Ombudsman of the discharge to the hospital. Review of R1's Progress Notes located under the Prog Note tab of the EMR, dated [DATE], revealed Writer contacted POA to know if he needed bed to be hold [sic]. Per POA No. During an interview on [DATE] at 11:36 AM, regarding the process for bed hold, the Social Services Director (SSD) stated, If a resident is their own responsible person, the nurses are supposed to explain the bed hold process to the resident and ask them if they want the bed hold. Then a carbon copy of the bed hold is sent with the resident and we keep the other. The SSD then stated, If they have a POA, the nurses are supposed to call the POA and go over what the bed hold is, the daily rate they would be responsible for, and the right to contact the Ombudsman regarding the decision or appeal. There is a section on the bottom of the bed hold document where the resident and/or representative would indicate they had been given the information, if they want a bed hold, or not, and the staff member who completed the form. When R1's EMR was reviewed with the SSD, she confirmed there was no documentation of a bed hold given to R1 or R1's representative. During an interview on [DATE] at 1:08 PM, and review of R1's EMR, the Assistant Director of</p> <p>(continued on next page)</p> | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 525422 | Facility ID: If continuation sheet Page 1 of 3 |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Nursing (ADON) stated, [name of R1] went out to the hospital on [DATE] and did not return. When asked if there was documentation of a bed hold in R1's EMR, the ADON reviewed the EMR and stated, I don't see one was done. During an interview on [DATE] at 1:35 PM, and review of R1's EMR, the Director of Nursing (DON) confirmed R1 was sent to the hospital on [DATE], did not return to the facility. The DON further confirmed there was no documentation in the EMR of a bed hold. During an interview on [DATE] at 2:11 PM, and review of R1's EMR, RN1 confirmed she was the nurse who sent R1 to the hospital on [DATE]. Regarding the bed hold, RN1 stated she recalled speaking to R1's responsible party about it over the phone, and he said no. However, when reviewing R1's EMR, RN1 confirmed there was no specific documentation of the bed hold being completed and what the cost per day would be. During an interview on [DATE] at 2:49 PM, regarding the bed hold policy, the Administrator stated, My expectation is that the nurses should be having a conversation with the POAs if they want to hold the bed. We have a carbon copy form, and they should be filling it out with the cost per day, the Ombudsman information, the right to appeal, and if they want to hold the bed or not. The Administrator further stated, If a resident is their own responsible person, my expectation would be for us to explain the process and give them a copy. That should be the process here. Regarding R1, the Administrator stated, I don't see the bed hold was done. During a phone interview on [DATE] at 3:50 PM, regarding the facility discharge of R1 on [DATE], the Ombudsman stated, I wasn't notified by the facility. I didn't receive any documentation from the facility related to discharge. 2. Review of the admission Record located under the Profile tab in the EMR revealed R9 was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Review of the admission MDS with an ARD of [DATE] in the EMR under the MDS tab revealed R9 had a BIMS score of 15 out of 15 which indicated R9 had no cognitive impairment. Review of the discharge return anticipated MDS with an ARD of [DATE] and located in R9's EMR under the MDS tab revealed the type of discharge was Unplanned. The Discharge status was to an acute hospital. R9 did not return to the facility upon discharge to the hospital. Further review of R9's EMR revealed no documentation a bed hold was discussed with R9 or the representative regarding the discharge to the hospital on [DATE]. There was no documentation of the cost of services per day, or if R9 chose to have a bed hold. There was also no documentation in the EMR the Ombudsman was notified of the discharge to the hospital. During a phone interview on [DATE] at 8:48 AM, regarding the bed hold for R9, the SSD stated, She did not return from the hospital. When asked if R9 or the representative received a bed hold, the SSD stated, I don't see we did one for her. 3. Review of the admission Record and located under the Profile tab in the EMR revealed R10 was admitted to the facility on [DATE] and discharged to the hospital on [DATE]. Review of the discharge return anticipated MDS with an ARD of [DATE] and located in R10's EMR under the MDS tab revealed the type of discharge was Unplanned. The Discharge status was to the hospital for abnormal vital signs. R10 did not return to the facility upon discharge to the hospital. Further review of R10's EMR revealed no documentation a bed hold was discussed with R10 or the representative regarding the discharge to the hospital on [DATE]. There was no documentation of the cost of services per day or if R10 chose to have a bed hold. There was also no documentation in the EMR the Ombudsman was notified of the discharge to the hospital. During a phone interview on [DATE] at 8:48 AM, regarding the bed hold for R10, the SSD stated I'm not seeing one was completed. The nurse should have completed one with her representative. During a review of the Admission/Discharge to/from Report from [DATE] to [DATE], and interview with the SSD on [DATE] at 11:36 AM, the SSD stated, I fax over a monthly list of our discharges to the Ombudsman the first Monday of the month. I don't hang on to those though. I just fax them. During a phone interview on [DATE] at 3:50 PM, regarding the Admissions/Discharge to/from Report a representative of the Long-Term</p> <p>(continued on next page)</p> | | |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Care Ombudsman program stated, I haven't gotten the monthly discharges list from the facility since [DATE]. We told them they needed to maintain documentation they were sending them to us. We are not being made aware. During a second interview on [DATE] at 4:16 PM, regarding the facility-initiated discharge notifications to the Ombudsman, the SSD stated, I print out the Admissions/Discharge report which shows who went home, went to the hospital, expired, or went to an assisted living. I just send them a fax, then throw that away. I don't hang on to any documentation that I faxed. Review of the facility's policy titled, Individual Bed Hold reviewed [DATE] revealed Policy-The individual, guardian, and/or individual representative will be informed upon admission and/or hospital/therapeutic leave of their bed hold options at the facility. Procedure: Upon transfer to hospital and/or therapeutic leave 1. Individual will be informed and receive a copy of the bed hold procedure and letter. 2. Options will be given for a decision to be made regarding bed hold status. 3. If individual is unable to make preference known, designed will contact individual representative to determine preference. 4. Response will be documented. 5. Life Coach, or designee, will contact the individual representative on the next working day to ensure that the representative understands the bed hold and return to facility information. Review of the facility's policy titled, Individual Transfer and Discharge reviewed [DATE], revealed Procedure: . 3. The appropriate Ombudsman will be notified of all facility-initiated discharges, including hospitalizations.</p> | | |