

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Mukwonago		STREET ADDRESS, CITY, STATE, ZIP CODE 837 E Veterans Way Mukwonago, WI 53149	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435</p> <p>Based on interview and record review, the facility did not ensure that 1 (R1) of 1 residents with an injury of unknown origin was reported to the State Survey Agency within the required reporting timeframe.</p> <p>R1's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting a bruise of unknown origin was submitted to the State Survey Agency on [DATE]. Nursing Home Administrator (NHA)-A stated in an interview that the Misconduct Incident Report was submitted to the State Survey Agency on [DATE], which is past the 5-business day required timeframe.</p> <p>Findings include:</p> <p>The facility policy with a last reviewed date of [DATE], titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property documents, in part: It is the policy of the facility that each individual will be free from Abuse . The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal Guidelines . 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. When making a report, Misconduct Incident Reporting (MIR) system will be used. 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 .</p> <p>R1 was admitted to the facility on [DATE].</p> <p>R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE], documents R1 is severely cognitively impaired.</p> <p>R1's progress note dated [DATE] at 1:23 PM documents: New bruise noted on left forearm. [R1] states [R1] bumped it on the machine. Resident does not remember when this happened. Bruise measures 7.5 x 6 [centimeters]. No pain with palpation. Skin is intact. Vitals stable.</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.

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: 525645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Mukwonago		STREET ADDRESS, CITY, STATE, ZIP CODE 837 E Veterans Way Mukwonago, WI 53149	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C, who was the CNA who first saw R1's bruise. CNA-C stated that CNA-C went into R1's room to help R1. R1 pointed at R1's wrist and told CNA-C to look at R1's wrist. CNA-C stated that CNA-C asked R1 how the bruise happened. R1 did not tell CNA-C how it happened but stated that it occurred last night. Surveyor asked if R1 mentioned that the bruise occurred while using the sit-to stand transfer device or if R1 mentioned bumping into the transfer device. CNA-C stated no. CNA-C stated that there was no transfer that CNA-C helped with that R1 hit R1's wrist on the transfer device. CNA-C stated that R1 does self-propel while R1 is in R1's wheelchair. CNA-C stated that R1 can be seen rolling in R1's room and moving belongings around. CNA-C thought that R1 might have bumped into something in R1's room and that could have been the cause of the bruise. Surveyor asked what CNA-C did after finding the bruise. CNA-C stated that CNA-C told the nurse.</p> <p>On [DATE] at 10:50 AM, Surveyor interviewed Registered Nurse (RN)-D, who was one of the nurses who assessed R1's bruise after it was found. RN-D stated that the bruise was brought to RN-D's attention by another nurse. RN-D stated that RN-D went to R1's room two times to see if R1 could tell RN-D how and when the bruise occurred. RN-D stated that R1 indicated that R1 bumped R1's left arm on the machine and pointed to the sit to stand transfer device. RN-D stated that the bruise was assessed and measured, R1's Power of Attorney and MD were notified, and administration was notified. Surveyor asked if R1 mentioned any names in association with how the bruise occurred. RN-D stated no.</p> <p>Surveyor reviewed the staff schedules and noted that CNA-C and CNA-E were some of the staff working on [DATE] the evening before R1's bruise was found.</p> <p>On [DATE] at 1:24 PM, Surveyor interviewed CNA-E. CNA-E stated that CNA-E has helped with transferring R1 in the past. Surveyor asked if there was ever a time that R1 was injured or bumped R1's arm during a transfer. CNA-E stated no. Surveyor asked if CNA-E recalled seeing or hearing about a bruise on R1's arm. CNA-E stated no but if CNA-E had seen the bruise, CNA-E would have alerted a nurse right away.</p> <p>Surveyor reviewed the facilities self report regarding R1's bruise. The self-report contained a summary of findings, an interview with R1, interviews with all other residents on R1's unit and 2 staff interviews. Surveyor did not locate a completed Misconduct Incident Report form documenting the submission of the investigative findings to the State Agency.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Mukwonago		STREET ADDRESS, CITY, STATE, ZIP CODE 837 E Veterans Way Mukwonago, WI 53149	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:53 PM, Surveyor interviewed NHA-A about the self-report on R1's bruise. NHA-A stated that NHA-A was made aware of the bruise on [DATE]. NHA-A indicated that NHA-A talked to R1. NHA-A asked R1 if any staff were involved when R1 received the bruise. R1 stated no. NHA-A asked R1 how the bruise happened, R1 pointed at R1's dresser drawer and then pointed to the sit to stand transfer device. NHA-A stated that R1 pointed more at the drawer. NHA-A stated that after the interview with R1, it was noted that a drawer in R1's dresser was not opening correctly, and maintenance had to come and fix R1's dresser drawer. NHA-A stated that resident interviews were completed, and NHA-A talked to staff. NHA-A stated that there have been no other injuries of unknown origin on the unit. NHA-A concluded that no abuse occurred and no one intentionally hurt R1. Surveyor asked about the report to the State Agency. NHA-A stated that the account that NHA-A uses to report an incident like this had expired. NHA-A stated that NHA-A created a new account. NHA-A tried multiple times to put in the new credentials to enter the report, but NHA-A was not successful. NHA-A sent an email to the Office of Caregiver Quality on [DATE] alerting the Agency of the bruise and the investigation. NHA-A stated that NHA-A submitted the final investigation (the five day) on [DATE] with all the attachments. Surveyor asked for evidence that the 5-day report was submitted. NHA-A state that it was submitted on the 22nd. NHA-A stated that the system accepted the report but there is nothing to give to Surveyor to provide evidence of the submission. NHA-A stated that NHA-A knew that the 5-day report was late but still wanted to make sure that the report was submitted.</p> <p>On [DATE] at 2:08 PM, NHA-A and Director of Nursing (DON)-B were notified of the concern that the final investigation findings of R1's injury of unknown origin were not submitted to State Agency within 5 working days of the incident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Mukwonago		STREET ADDRESS, CITY, STATE, ZIP CODE 837 E Veterans Way Mukwonago, WI 53149	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435</p> <p>Based on interviews and record review, the facility did not ensure an injury of unknown origin was thoroughly investigated for 1 (R1) of 1 residents reviewed.</p> <p>Facility staff found a bruise on R1's left forearm on 4/13/25. Certified Nursing Assistant (CNA)-C informed Surveyor that R1 told CNA-C that the bruise happened the night before. R1 told Registered Nurse (RN)-D that R1 bumped R1's arm on the sit-to-stand transfer device. The facility investigation into R1's bruise included 2 staff interviews from CNA-C and RN-D. The facility did not interview or get statements from other staff members that had worked with R1 in the previous shifts before the bruise was found.</p> <p>Findings include:</p> <p>The facility policy with a last reviewed date of 11/8/2023, titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property documents, in part: It is the policy of the facility that each individual will be free from Abuse . It is the policy of this facility that reports of abuse are promptly and thoroughly investigated . The investigation is the process used to try to determine what happened . Investigation of injuries of unknown origin or suspicious injuries: must be immediately investigated to rule out abuse .</p> <p>R1 was admitted to the facility on [DATE].</p> <p>R1's Quarterly Minimum Data Set (MDS) assessment dated [DATE], documents R1 is severely cognitively impaired.</p> <p>R1's progress note dated 4/13/25 at 1:23 PM documents: New bruise noted on left forearm. [R1] states [R1] bumped it on the machine. Resident does not remember when this happened. Bruise measures 7.5 x 6 [centimeters]. No pain with palpation. Skin is intact. Vitals stable.</p> <p>On 5/14/25 at 10:40 AM, Surveyor interviewed R1. Surveyor asked about R1's bruise that R1 had about a month ago. R1 did not recall the bruise. Surveyor asked if R1 felt safe at the facility. R1 stated yes. Surveyor asked if R1 was in pain. R1 stated No. Surveyor asked if R1 had any concerns with facility staff. R1 stated No.</p> <p>On 5/14/25 at 10:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C, who was the CNA who first saw R1's bruise. CNA-C stated that CNA-C went into R1's room to help R1. R1 pointed at R1's wrist and told CNA-C to look at R1's wrist. CNA-C stated that CNA-C asked R1 how the bruise happened. R1 did not tell CNA-C how it happened but stated that it occurred last night. Surveyor asked if R1 mentioned that the bruise occurred while using the sit-to stand transfer device or if R1 mentioned bumping into the transfer device. CNA-C stated no. CNA-C stated that there was no transfer that CNA-C helped with that R1 hit R1's wrist/arm on the transfer device. CNA-C stated that R1 does self-propel R1's wheelchair. CNA-C stated that R1 can be seen rolling in R1's room and moving belongings around. CNA-C thought that R1 might have bumped into something in R1's room and that could have been the cause of the bruise. Surveyor asked what CNA-C did after finding the bruise. CNA-C stated that CNA-C told the nurse.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Mukwonago		STREET ADDRESS, CITY, STATE, ZIP CODE 837 E Veterans Way Mukwonago, WI 53149	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted that R1 told CNA-C that the bruise occurred the night before the bruise was found.</p> <p>On 5/14/25 at 10:50 AM, Surveyor interviewed Registered Nurse (RN)-D, who was one of the nurses who assessed R1's bruise after it was found. RN-D stated that the bruise was brought to RN-D's attention by another nurse. RN-D stated that RN-D went to R1's room two times to see if R1 could tell RN-D how and when the bruise occurred. RN-D stated that R1 indicated that R1 bumped R1's left arm on the machine and pointed to the sit to stand transfer device. RN-D stated that the bruise was assessed and measured, R1's Power of Attorney and MD were notified, and administration was notified. Surveyor asked if R1 mentioned any names in association with how the bruise occurred. RN-D stated no.</p> <p>Surveyor noted that R1 told RN-D that the bruise happened by bumping R1's arm on the sit-to-stand transfer device.</p> <p>Surveyor reviewed the facilities Self report regarding R1's bruise. The self-report contained a summary of findings, an interview with R1, interviews with all other residents on R1's unit and 2 staff interviews (CNA-C and RN-D). Surveyor noted that the facility did not review the staff schedules from the previous shifts to interview staff that were working prior to the development of the bruise. Surveyor noted that staff on previous shifts were not asked if there was a transfer that R1 hit R1's arm on the transfer device, were not asked if any bruising or other skin alteration was noted in the previous shifts and were not asked if they witnessed anything that would've caused R1 to bruise.</p> <p>Surveyor reviewed the staff schedules and noted that CNA-C and CNA-E were some of the staff working on 4/12/24 the evening before R1's bruise was found.</p> <p>On 5/14/25 at 1:24 PM, Surveyor interviewed CNA-E. CNA-E stated that CNA-E has helped with transferring R1 in the past. Surveyor asked if there was ever a time that R1 was injured or bumped R1's arm during a transfer. CNA-E stated no. Surveyor asked if CNA-E recalled seeing or hearing about a bruise on R1's arm. CNA-E stated no but if CNA-E had seen the bruise, CNA-E would have alerted a nurse right away.</p> <p>Surveyor attempted to interview other staff working the shifts prior to R1's development of the bruise but was unsuccessful.</p> <p>Surveyor noted that the local police department completed an investigation into R1's bruise. Surveyor reviewed the police report with an incident date of 4/13/25. Surveyor noted that after investigation, the case was closed and there were no charges filed in relation to R1's bruise.</p> <p>On 5/14/25 at 12:53 PM, Surveyor interviewed NHA-A about the self-report on R1's bruise. NHA-A stated that NHA-A was made aware of the bruise on 4/14/25. NHA-A indicated that NHA-A talked to R1. NHA-A asked R1 if any staff were involved when R1 received the bruise. R1 stated no. NHA-A asked R1 how the bruise happened, R1 pointed at R1's dresser drawer and then pointed to the sit to stand transfer device. NHA-A stated that R1 pointed more at the drawer. NHA-A stated that after the interview with R1, it was noted that a drawer in R1's dresser was not opening correctly, and maintenance had to come and fix R1's dresser drawer. NHA-A stated that resident interviews were completed, and NHA-A talked to staff. NHA-A stated that there have been no other injuries of unknown origin on the unit. NHA-A concluded that no abuse occurred and no one intentionally hurt R1. Surveyor asked if there are any additional staff statements or interviews that were completed. NHA-A stated that NHA-A would get the staff statements for Surveyor. NHA-A returned to Surveyor with CNA-C and RN-D's statements.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Lindengrove Mukwonago		STREET ADDRESS, CITY, STATE, ZIP CODE 837 E Veterans Way Mukwonago, WI 53149	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 2:08 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B of the concern that a thorough investigation into R1's bruise was not completed. The facility did not interview staff who worked with R1 in the shifts prior to R1's development of the bruise. No additional information was provided.		