| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525645 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lindengrove Mukwonago | 837 E Veterans Way<br>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 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>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility did not ensure 1 (R40) of 2 residents received adequate supervision and assistance devices to prevent accidents.* R40's fall on 11/16/25 was not thoroughly investigated and a root cause was not determined to help prevent further falls. On 12/9/25 & 12/10/25, Dycem was not observed on R40's wheelchair per R40's falls plan of care.Findings include:The facility's policy titled, Falls and last reviewed 5/8/25 documents under the policy section: Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls.R40's diagnoses include dementia (loss of cognitive function that interferes with a person's daily life and activities), hypertension (high blood pressure), and anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating).R40's annual MDS (minimum data set) with an assessment reference date of 8/27/25 has a BIMS (brief interview mental status) score of 7 which indicates severe cognitive impairment. The MDS documents that: R40 is assessed as being dependent for rolling left and right & toileting hygiene and requiring substantial/maximal assistance for bed/bed to chair transfer and toilet transfer. R40 is frequently incontinent of urine and occasionally incontinent of bowel. R40 has fallen since prior assessment with one fall no injury.R40's fall CAA (care area assessment) dated 9/3/25 documents under the care plan consideration section: CAA triggered for falls due to risk factors resulting from balance problems: Not steady, needs assistance for moving from seated to standing position, moving on and off toilet and surface-to-surface transfer; Resident receives physician ordered anti-depressant medications, Refer to MAR (medication administration record). Resident has fall history. Resident has had one fall without injury during this assessment period, refer to DQI documentation. Nursing staff assists resident with ADLs (activities daily living) as needed according to facility policy. Resident is at risk for fall related injury. No referrals at this time, will proceed to care plan with goal to have no fall related injuries. R40's resident is moderate risk for falls care plan initiated 12/21/23 & revised 8/27/25 documents the following interventions:*Anticipate and meet the resident's needs. Initiated 8/23/24.*Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Initiated & revised 8/23/24.*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 for assistance. Initiated 8/23/24.*PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered or PRN (as needed). Initiated 8/23/24.*Provide reminders for resident to call for assist with transfers from w/c. Lock w/c brakes for resident. Initiated 8/27/24.*Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 3/21/25.*Ensure that the resident is wearing appropriate footwear\describe correct client footwear i.e. brown leather shoes, tartan bedroom slippers, black non-skid socks) when ambulating, transferring or mobilizing in w/c (wheelchair). Initiated 3/21/25 & revised 3/28/25.*The resident needs activities that minimize the potential for falls while providing diversion and distraction. Initiated 3/21/25 and revised 3/28/25.*The 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). Initiated 3/21/25 and revised 3/28/25.*Reminder signs placed in bathroom for resident to call for assist with toilet transfers. Initiated 3/28/25.*Offer recliner after dinner. Initiated 9/10/25.*The resident needs to be evaluated for and supplied\adaptive equipment or devices as needed). And as needed for continued appropriateness and to ensure least restrictive device or restraint. Initiated and revised 9/10/25*Dysem on w/c cushion. Initiated 11/17/25.R40's Visual/Bedside Kardex Report as of 12/10/25 under the resident care section includes Dysem on w/c cushion.R40's fall risk evaluation dated 8/27/25 has a score of 17 which indicates at risk. R40's fall risk evaluation has a score of 13 which indicates at risk.R40's nurses note dated 11/16/25, at 2012 (8:12 p.m.), and written by Licensed Practical Nurse (LPN)-E documents Resident found on floor in-between bed and window leaning up against wheelchair. Call light within reach proper footwear worn. Resident stated: I was trying to sit up and I slipped. No noted injury VSS (vital signs stable) denies pain. Writer CNA (Certified Nursing Assistant) RN (Registered Nurse) assisted resident off floor into wheelchair. [Name] RN nurse supervisor aware updated stated will call POA (Power of Attorney) [Name] to update. [Physician's name] updated.On 12/8/25, at 9:44 a.m., Surveyor observed R40 sitting in a wheelchair in her room. Surveyor observed there is a cushion in R40's wheelchair and R40 is wearing gripper socks on her feet. Surveyor asked R40 how she was doing. R40 stated trying to get warm. Surveyor |