STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019674	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN COURT MUKWONAGO	845 E VETERANS WAY MUKWONAGO, WI 53149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/25/2024, Surveyor conducted 1 complaint investigations at LindenCourt Mukwonago. Three deficiencies were identified. The complaint was substantiated. Census: 20	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a 30-day advance written notice was provided to the resident or legal representative and the provider did not assist in relocating the resident to a suitable living arrangement that would meet the needs of the resident Resident 1's legal representative was provided a 2 day advance written notice that Resident 1 was	N 326		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 326	Continued From page 1	N 326		

discharged to an inpatient acute care via emergency services.

Findings include:

On 06/19/2024, the Department received a complaint regarding involuntary discharge.

On 07/25/2024, Surveyor reviewed Resident 1's record. S/he was admitted 05/06/2024. Prior to admission, Resident 1 lived at home with Family Member D. Diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, moderate, with agitation; depression; and insomnia. Resident 1 was under guardianship of person and estate.

Facility Progress Note dated 05/28/2024 at 3:19 PM-
" ...Resident was attempting to elope on Sunday (5/26). Was unable to redirect and resident got outside. Staff attempted to get resident back inside when [s/he] grabbed a rock and was threatening to hit staff with the rock. A family member of another resident saw this and intervened. Police were called and resident was transported to ER for evaluation. Writer spoke with administration and resident cannot return to facility due to the imminent risk of serious harm to the health and safety of other residents and employees... [His/her] behaviors appeared to have been becoming less frequent but the intensity has gotten much worse. [S/He] cannot be redirected and will grab objects (on Sunday it was a Rock [sic], previously it was glass plates) to use as a weapon. This puts not only the staff in at [sic] imminent risk of serious harm but also other residents. Upon writer's assessment prior to [him/her] moving in writer specifically asked [Family Member D] about behaviors and violence.

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N 326	Continued From page 2 [Family Member D] states [s/he] was rarely behavioral at times would try to leave the house but is easily redirected. Unfortunately [sic] if writer was not given correct information writer is not able to make informed decisions about meeting [his/her] care needs ..." Notice of Discharge dated 05/31/2024 to Family Member D from Administrator A- " ...This letter serves as notice of your discharge from LindenGrove Communities ...The date of your discharge is 5-26-2024 ...Due to imminent risk to self and others discharge was to inpatient acute care via emergency services ..." On 07/25/2024 at 4:05 PM, Surveyor discussed concern of improper involuntary discharge with Administrator A, Director of Nursing B and Assistant Director of Nursing C. Administrator A stated the onsite preadmission assessment did not show how volatile Resident 1's behaviors were and due to the significant imminent dangers to residents, staff, and family members we could not let him/her return to the facility. Cross Reference: N0328 DHS 83.31(4)(c) Involuntary Notice Discharge Requirements N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 326		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth	N 328		

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the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the Notice of Discharge issued to Resident 1's legal representative contained the correct appeal contact information of the Department's regional office director or advocacy contact information of the regional ombudsman.

Findings include:

On 06/19/2024, the Department received a complaint regarding involuntary discharge.

On 07/25/2024, Surveyor reviewed Resident 1's record. S/he was admitted 05/06/2024. Prior to admission, Resident 1 lived at home with Family Member D. Diagnoses included Alzheimer's

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N 328	Continued From page 4	N 328		

disease with late onset, dementia in other diseases classified elsewhere, moderate, with agitation; depression; and insomnia. Resident 1 was under guardianship of person and estate.

Notice of Discharge dated 05/31/2024 to Family Member D from Administrator A- " ...This letter serves as notice of your discharge from LindenGrove Communities ...The date of your discharge is 5-26-2024 ...Due to imminent risk to self and others discharge was to inpatient acute care via emergency services ...You have a right to relocation assistance and to be prepared for and oriented to being transferred/discharged. You also have a right to contact an advocate to discuss this notice, and to seek assistance. You may call or write an Ombudsman (for persons over age 60) ...
Board of Aging and Long Term Care
[Ombudsman F]
1402 Pankrazt Street, Suite 111
Madison, WI 563704-4001
Phone: 1-800-815-0015
Fax: 608-246-7001 ...
[Ombudsman F's email address]

You may also appeal this transfer or discharge decision by: 1. Writing a letter, within 97) days of having received this notice to the regional office of the Department of Health Services-Division of Quality Assurance (DQA) asking for a review of this discharge decision and stating why this discharge should not take place ...The name/address/phone number for the regional office of the Wisconsin Department of Health Services [DHS]-Division of Quality Assurance (DQA) is:
DQA Southeastern Regional Office
[DQA Reg. Field Ops Dir. G]
819 N. 6th street, Room 609B

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N 328	Continued From page 5 Milwaukee, WI 53203-1606 Phone: 414-227-5000 Fax: 414-227-4139 ..." Ombudsman F's email address and DHS/DQA Southern Regional Office (SRO) director's name, address, phone number and fax number were incorrect on the discharge notice. On 07/25/2024 at 4:05 PM, Surveyor discussed concern of incorrect advocacy and appeal contact information on Resident 1's Notice of Discharge with Administrator A, Director of Nursing B and Assistant Director of Nursing C. Administrator A stated they realized the contact information was incorrect after it was issued. Cross Reference: N0326 DHS 83.41(4) (a) Notice Of Facility Initiated Discharges N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 328		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.	N 389		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure when there was a change the resident's needs, abilities or physical or mental condition, the individual service plan was reviewed and revised.

Resident 1's individual service plan (ISP) was not revised when s/he displayed physically and verbally aggressive behaviors and restlessness or when as needed psychotropic medication was started for behaviors.

Findings include:

On 06/19/2024, the Department received a complaint regarding involuntary discharge due to behaviors.

On 07/25/2024 at 1:29 PM, Surveyor interviewed ADON C who stated s/he assessed Resident 1 in person prior to admission and Family Member D's only concern regarding behaviors was exit seeking and Resident 1 became agitated once during a violent television show but calmed when Family Member D turned it off. ADON C stated after admission, Resident 1 knocked on other resident's doors, aggressively crumbled a cookie in his/her hand then hit a staff, put his/her face close to staff's faces and yell, aggressively approached other residents, became verbally upset when staff tried to engage him/her in 1:1 activity. ADON C stated when Resident 1 attempted to elope staff were unable to redirect him/her back in so risperidone was changed. ADON C stated as needed [PRN] lorazepam was added but since his/her behaviors escalated so quickly they usually were usually unable to

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administer it. (Note: lorazepam and risperidone are psychotropic medications used to treat behaviors and/or mood).

On 07/25/2024 at 1:34 PM, Surveyor interviewed Med Tech H who stated once during medication pass, Resident 1 had a sudden mood change, threw the medication cup and air punches at him/her, and threatened to kill him/her. Med Tech H stated once s/he heard a staff screaming and upon checking, witnessed Resident 1 cornering and punching the staff. Med Tech H stated Resident 1 was not redirectable and began throwing punches at him/her also so the nurse manager was called to assist. Med Tech H stated Resident 1 displayed behaviors almost every day after admission date, and initially s/he was calm during Family Member D's visits but then became verbally abusive toward Family Member D.

On 07/25/2024 at 1:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA) I who stated Resident 1 was very restless, agitated, and persistent. CNA I stated Resident 1 was determined to leave the memory care unit and encouraged other residents to also leave. CNA I stated it was difficult to keep Resident 1 relax and engaged.
On 07/25/2024 at 3:39 PM, Surveyor interviewed CNA J who stated s/he worked PM and night shifts. CNA J stated Resident 1 was combative and had tried to hit him/her, yelled, restless including up all night a couple of times and entering other resident rooms, aggressively approached other residents, was resistive to cares including changing clothes when incontinent of bowel and bladder, and hard to redirect. CNA J stated Resident 1 displayed the same behaviors when Family Member D visited but did allow Family Member D to provide cares

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and showers.

On 07/25/2024, Surveyor reviewed Resident 1's record. S/he was admitted 05/06/2024. Prior to admission, Resident 1 lived at home with Family Member D. Diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, moderate, with agitation; depression; and insomnia. Resident 1 was under guardianship of person and estate.

Family Care Placement Summary dated 04/11/2024 (summarized): Resident 1 exhibited no verbal aggression, physical aggression, property destruction, inappropriate sexual behaviors, self-injurious behaviors or other behaviors except elopement attempts and wandering outside the home. Trigger listed for elopement attempts and wandering outside the home was confusion due to diagnoses of Alzheimer's disease. Resident 1 enjoyed animals, puzzles, reading, going for rides, his/her cat, and walking outside.

Facility Preadmission Assessment signed and dated 04/23/2024 by Assistant Director of Nursing (ADON) C (summarized): Resident 1 was oriented to person, disoriented to place and time with short- and long-term memory loss. S/he was able to communicate needs and was not destructive of self or property but was at risk for elopement (would require a wander guard at facility) and displayed other behaviors (other behaviors not specified) on rare occasion depending on mood.

Admission Assessment signed and dated 05/06/2024 by ADON C (summarized): Resident 1 was incapable of independent decision making, required assistance with re-direction and

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orientation. Ten behaviors (including "other") were listed on the assessment, 9 were not checked off, "Demonstrates anxious/paranoid or suspicious behaviors" was checked. S/he was at risk for elopement and not resistive to cares.

Physician orders included: risperidone 0.5 MG ½ tablet in evening (start date 05/06/2024, discontinued 05/07/2024; risperidone 0.25 MG 1 tablet twice daily for dementia in other diseases classified elsewhere, moderate, with agitation (start dated 05/08/2024); lorazepam 0.5 MG 1 tablet twice daily as needed (PRN) for anxiety or agitation (start date 05/07/2024); memantine HCl 10 MG 1 tablet twice daily for dementia (start date 05/06/2024).

Psychiatry progress note dated 05/07/2024- " ...Chief Complaint anxiety, agitation [increased] around 3 pm, history hallucinations, aggression at home ...Symptom Review ...sleep disturbance depressed mood, anxiety/panic ...anger/irritability ...physical aggression [increased] pms, better since [prescription] risperidone ...hallucinations [history] well controlled on risperidone ...Mental Status Exam ...Speech ...anomia [inability to find the correct word] ...Mood ...anxious ...Impression: ...Alzheimer's ...severe ...with ...depression, anxiety, psychosis, physically ...aggressive ..."

Facility Behavior Note dated 05/06/2024 3:19 PM- "[Family Member D] left for the evening and resident is very upset. Exit seeking and angry. Multiple attempts made to redirect. Staff is allowing [him/her] to walk about the unit and redirect as needed. [Primary Care Physician] updated."

Email from ADON C to Managed Care Organization RN E dated 05/07/2024 at 2:38 AM "

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N 389	Continued From page 10 ...We had an incident after lunch today. [Resident 1] did hit staff. We were able to redirect other residents out of [his/her] way, so no other residents were harmed. [Family Member D] was called by the time [s/he] came in. [sic] [S/He] had sat [him/herself] down and calm [sic] down. New orders for increased risperidone and PRN [as needed] lorazepam obtained from psych provider. PRN lorazepam was given. Family and staff made aware that if behaviors become violent towards staff or residence [sic], resident will need to be sent out to ER ..." Facility Self-Report dated 05/14/2024- Incident Date: 05/10/2024: " ...Resident was found in the parking lot adjacent to the Memory Care Court. Returned to Court with out [sic] incident by staff. Previous to incident resident had completed lunch and as [sic] walking in the dinning[sic]/TV rooms. Resident was not in distress, no injuries [sic] walked with staff back to the unit without assistance. No further incidents to date ...contacted lawn staff to close gate exiting the courtyard after access as gate was not closed ..." Facility Progress Note dated 05/28/2024 at 3:19 PM- " ...Resident was attempting to elope on Sunday (5/26). Was unable to redirect and resident got outside. Staff attempted to get resident back inside when [s/he] grabbed a rock and was threatening to hit staff with the rock. A family member of another resident saw this and intervened. Police were called and resident was transported to ER for evaluation. Writer spoke with administration and resident cannot return to facility due to the imminent risk of serious harm to the health and safety of other residents and employees... [His/her] behaviors appeared to	N 389		

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have been becoming less frequent but the intensity has gotten much worse. [S/He] cannot be redirected and will grab objects (on Sunday it was a Rock [sic], previously it was glass plates) to use as a weapon. This puts not only the staff in at [sic] imminent risk of serious harm but also other residents. Upon writer's assessment prior to [him/her] moving in writer specifically asked [Family Member D] about behaviors and violence. [Family Member D] states [s/he] was rarely behavioral at times would try to leave the house but is easily redirected. Unfortunately [sic] if writer was not given correct information writer is not able to make informed decisions about meeting [his/her] care needs ..."

Facility Self-Report dated 05/29/2024-
Incident Date: 05/26/2024: " ...Resident was observed walking toward the door and left the building through the front entrance. Staff approached and resident became aggressive. An additional staff was summoned to help. Resident chased staff member and was punching at staff. [S/He] then picked up a rock and made motions/verba; [sic] threats to throw the rock. Resdident [sic] was yelling and shouting [s/he] was going home. A [family member] of another resident attempted to talk with [Resident 1] who became aggressive, visitor got rock and resident continued to swing at visitor who held resident [sic] so that [s/he] could not attack others. Police were called and toolk [sic] incident control and transported resident from propetry [sic] via EMT transport ...Action Take to Ensure Resident's Health, Safety, and Well-Being Emergency services were contacted to assist in providing safety for the residenet [sic] fellow residtnts [sic] visiotrs [sic] and staff. Resident was transported for inpatient care and treatment. The resident will not be returning to LindenGrove- Mukwonago ..."

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N 389	Continued From page 12 Notice of Discharge dated 05/31/2024 to Family Member D from Administrator A- " ...This letter serves as notice of your discharge from LindenGrove Communities ...The date of your discharge is 5-26-2024 ...Due to imminent risk to self and others discharge was to inpatient acute care via emergency services ..." ISP dated 05/06/2024: In the area of Behaviors- "[Goal] Will be able to identify factors/interventions that help to prevent/minimize inappropriate behaviors ... [Interventions] Receives mental health services through: [name of provider] Date initiated: 05/06/2024 Revision on: 05/06/2024 Report changes from baseline behaviors to Nurse. Date initiated: 05/06/2024 Revision on: 05/06/2024 Responds to reorientation and redirection when wandering. Date initiated: 05/06/2024 Revision on: 05/06/2024" In the area of Medications- "[Goal] Will be supported to take all medications safely and as ordered Date Initiated: 05/06/2024 [Interventions]...Needs help with medications due to cognitive loss. Date Initiated 05/06/2024 Revision on: 05/06/2024..." In the area of Cognition-"[Goal] Will be supported to make appropriate decisions about their care and environment. Date initiated: 05/06/2024 Revision on: 05/06/2024 [Interventions] Elopement Risk: exit seeking Date initiated: 05/06/2024 Revision on: 05/06/2024 ...Has disorientation or difficulty recalling/retaining information. Needs cueing. Date initiated: 05/06/2024 Revision on: 05/06/2024 Requires reminders for activities. Date initiated: 05/06/2024 Revision on: 05/06/2024 Requires reminders for	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019674	A. BUILDING: _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN COURT MUKWONAGO	845 E VETERANS WAY MUKWONAGO, WI 53149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 389	Continued From page 13 meals. Date initiated: 05/06/2024 Revision on: 05/06/2024" In the area of Elopement Risk- "[Goal] Safety will be maintained. Date initiated 05/06/2024. Target Date: 11/02/2024 [Interventions] Wears a monitoring device wonder [sic] guard as ordered by health care practitioner Date initiated: 05/06/2024 Revision on: 05/06/2024" Resident 1's ISP was not updated to address aggressive physical and verbal behaviors toward staff, aggressively approaching other residents and entering their rooms, resisting cares, sudden mood changes, etc. On 07/25/2024 at 4:05 PM, Surveyor discussed concern that Resident 1's ISP had not been updated when Resident 1 displayed behaviors not identified on the assessment with Administrator A, Director of Nursing (DON) B and ADON C. DON B stated Resident 1's behaviors improved a bit with the PRN lorazepam then became more frequent and violent. DON B stated they were trying to predict the behaviors and assist the staff with interventions and wanted to update the ISP with effective interventions but none of the interventions were effective. Cross Reference: N0326 DHS 83.41(4) (a) Notice Of Facility Initiated Discharges N0328 DHS 83.31(4)(c) Involuntary Notice Discharge Requirements	N 389		