STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019675	A. BUILDING: _____ B. WING _____	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDENCOURT WAUKESHA	2330 W MICHIGAN AVE WAUKESHA, WI 53188

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N 000	Initial Comments On 05/05/2026, Surveyor conducted 1 complaint investigation at LindenCourt Waukesha. Three deficiencies were identified. Two of 3 deficiencies were repeat violations. See Statement of Deficiency (SOD) XDGS11, dated 05/31/2024. The complaint was substantiated. Census: 46	N 000		
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. This Rule is not met as evidenced by: Based on record observation, record review and interview, the provider did not ensure the individual service plan (ISP) was revised when there was a change in resident's needs, abilities or physical or mental condition.	N 389		

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

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N 389	Continued From page 1	N 389		

Resident 1's ISP did not specifically identify risk for bruising and skin tears or interventions to prevent skin issues, refusals of oxygen saturation (SPO2) checks or refusals of gait belt use.

This is repeat deficiency. See Statement of Deficiency XDGS11, dated 05/31/2024.

Findings include:

On 04/29/2025, the Department received a complaint regarding bruising.

On 05/05/2026, Surveyor interviewed Resident 1 who showed Surveyor the following bruises:
1. approximately 4" x 2 ½ inches located on right upper bicep
2. approximately 1" diameter located approximately 1" above elbow,
3. approximately 1 ¼" located top of right wrist and
4. approximately 1" inch diameter located above ring finger on left hand.
Resident stated s/he bruised easily due to his/her blood thinner (medication) and s/he did not allow staff to use a gaitbelt during transfers because s/he did not like it.

On 05/05/2026, Surveyor reviewed Resident 1's record.
Observation notes:
04/28/2026 at 12:52 PM- "Resident bumped [right] lateral calf getting out of bed and opened a skin tear. Bandaged x3 on day shift with 4x4 and gauze. Resident refused to lie down to get it to stop bleeding. Stated [s/he] wanted to wait until after lunch. Resident requested to go to bed after lunch-changed the dressing again."
04/30/2026 at 3:41 PM- "Resident has bruising on right upper arm, after looking into this is

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N 389	Continued From page 2 consistent with a blood pressure cuff that is used to obtain [his/her] vitals." Physician orders included: clopidogrel bisulfate (Plavix) 75 MG "TAKE 1 TABLET DAILY BY MOUTH MONITOR FOR BLEEDING, LOOK FOR DARK STOOLS, BRUISING ON SKIN, NOSE BLEEDS, COUGHING UP BLOOD" (started 02/20/2026 and discontinued 05/01/2026) and "Obtain SPO2 every shift, chart resident SPO2" (start date 10/20/2025). Medication Administration Record (MAR) dated 04/01/2026-005/04/2026: Staff documented resident refusals 5 times on AM shift, 4 times on PM shift and 1 time on Night shift. Staff did not document whether or not they checked his/her SPO2 19 times on night shift. ISP dated 04/27/2026 (summarized): In the area of Bathing: " ...Check skin with bath/shower and report and reddened/open areas to Nurse ..." In the area of Transfers: " ...Will be able to transfer safely with the assistance of 1. Able to get in and out of bed, chair, car, etc., with assistance of 1. Report any changes in ability to transfer to Nurse." In the area of Skin Condition: " ...Special skin issues. Interventions are: dressing changes." In the area of Behaviors: "Will be able to identify factors/interventions that help to prevent/minimize inappropriate behaviors ...Exhibits inappropriate behavior: yelling, cursing at residents and staff ...staff to escort resident to [his/her] room when [s/he] acts out if [s/he] refuses to desist ...Staff to talk calmy and reassure resident that they are safe ...Will not act out in a way that is harmful to self or others."	N 389		

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N 389	Continued From page 3 In the area of Assistive Devices: "Will be able to move about the community with assistance, Uses wheelchair for mobility." In the area of Oxygen Use: "Will follow all safety guidelines for the use of oxygen. Monitor for increasing difficulty breathing and report to nurse/MD. Staff to ensure [Resident 1] is wearing [his/her] [oxygen] at all times. Check that [oxygen] is in place at bedtime" The ISP did not identify risk of bruising and skin tears or interventions to prevent bruising and skin tears and did not identify behavior of refusing SPO2 monitoring. On 05/05/2026 at 11:57 AM, Surveyor interviewed Nurse Supervisor A who stated Resident 1 was at high risk for skin tears possibly due to previous lifestyle habits and chemotherapy treatments. On 05/05/2026 at 1:06 PM, Surveyor interviewed Assistant Administrator C who stated Resident 1 refused to have SPO2 checked since admission. Assistant Administrator C verified the physician order to check SPO2 every shift including night shift and physician and hospice were notified of the refusals. On 05/05/2026 at approximately 3:00 PM, Surveyor discussed concern of ISP not updated with Administrator B, Assistant Administrator C and Nurse Supervisor A. Nurse Supervisor A stated Resident 1 profusely refused cares during night shift, the large bruise on right upper bicep was caused by a blood pressure cuff and not surprising due to Resident 1's blood thinner medication. Nurse Supervisor A stated Resident 1 did not like the gait belt and if s/her were to start falling during a transfer staff would need to grab onto Resident 1's body. Nurse Supervisor A stated staff needed to be very careful during	N 389		

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N 389	Continued From page 4 cares due to Resident 1's fragile skin. Assistant Administrator C stated they added staff to ensure Resident 1 wore oxygen at all times after an incident when staff forgot to apply the oxygen at bedtime.	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the	N 431		

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N 431	Continued From page 5	N 431		

provider did ensure serves were provided to meet all the needs of the resident in the area of health monitoring.

Staff did not monitor Resident 1's oxygen saturation levels (SPO2) as ordered by physician.

This is a repeat deficiency. See Statement of Deficiency (SOD) XDGS11, dated 05/31/2024.

Findings include:

On 01/29/2026, the Department received a complaint alleging residents supplemental oxygen was mismanaged.

On 05/05/2026, Surveyor reviewed Resident 1's record. S/he was admitted 10/20/2025. Diagnoses included chronic obstructive pulmonary disease (COPD).

Physician orders included "Obtain SPO2 every shift, chart resident SPO2" (start date 10/20/2025).

Medication Administration Record (MAR) dated 04/01/2026-05/04/2026:
Staff did not document whether or not they obtained SPO2 on:
04/08/2026 night shift
04/10/2026-04/15/2026 night shifts
04/17/2026-04/19/2026 night shifts
04/27/2026 AM shift and night shifts
04/28/2026 night shift
04/28/2026 night shift
04/29/2026 AM and night shifts
04/30/2026 night shift
04/31/2026 night shift
05/01/2026-05/04/2026 night shifts

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N 431	Continued From page 6 On 05/05/2026 at approximately 3:00 PM, Surveyor discussed concern of SPO2 not monitored as ordered with Administrator B, Assistant Administrator C and Nurse Supervisor A. Nurse Supervisor A stated Resident 1 profusely refused cares during night shift, and Nurse Supervisor A stated if staff did not document obtaining the SPO2 then it probably was not obtained.	N 431		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure the resident right to prompt and adequate treatment for 2 of 2 residents reviewed.	Y3244		

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Y3244	Continued From page 7 In January 2025, staff did not apply Resident 1's oxygen as ordered by the physician and s/he experienced long call pendant wait times. Resident 2 experienced long call pendant wait times. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 48 residents within the client groups of terminally ill, advanced aged, physically disabled and irreversible dementia/Alzheimer's. On 01/29/2026, the Department received a complaint alleging mismanagement of supplemental oxygen and long call pendant wait times. On 05/05/2026, Surveyor reviewed Resident 1's and Resident 2's records. Example 1- Resident 1 Resident 1 was admitted 10/20/2025. Diagnoses included generalized muscle weakness, unspecified abnormalities of gait and mobility, and need for assistance with personal care. Receipt of Grievance form dated 02/02/2026 (completed by Assistant Administrator C) (summarized): On 02/02/2026, Resident 1 informed Assistant Administrator C that a few nights prior to 02/02/2026 staff forgot to put Resident 1's supplemental oxygen on him/her at bedtime. This was confirmed with the residential aid. The oxygen concentrator was moved closer to bed so Resident 1 could reach it, reminder to apply oxygen at bedtime was added to the medication administration record (MAR), and	Y3244		

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Y3244	Continued From page 8	Y3244		

reminder signs were hung in Resident 1's room.

Call pendant log (paper copy) dated 04/22/2026-05/242026:
Wait times exceeding 20 minutes (reset times, when staff answered the call pendant were not displayed on the log for the following):

04/22/2026 2:02 AM-2:36 AM 34 minutes
04/26/2026 4:42 PM- 5:06 PM 24 minutes
04/26/2026 10:23 PM-10:49 PM- 26 minutes
04/27/2026 9:29 AM-9:55 AM 26 minutes
04/27/2026 1:58 PM-2:22 PM 24 minutes
04/27/2026 8:13 PM-9:07 PM 54 minutes
04/25/2026 2:20 AM-2:40 AM 22 minutes
04/26/2026 4:42 PM-5:06 PM 24 minutes
04/28/2026 6:37 AM-6:59 AM 22 minutes
04/28/2026 12:37 PM-1:03 PM 26 minutes
04/29/2026 1:04 PM-2:04 PM 60 minutes
04/30/2026 1:14 PM-1:36 PM 22 minutes
05/01/2026 2:53 PM-3:19 PM 26 minutes
05/02/2026 2:19 AM- 2:45 AM 26 minutes
05/02/2026 6:20 AM-6:46 AM 26 minutes
05/02/2026 9:49 AM-10:13 AM 24 minutes
05/02/2026 11:40 AM-12:06 PM 36 minutes
05/02/2026 1:23 PM-1:47 PM 24 minutes
05/03/2026- 9:45 AM-10:11 AM 26 minutes
05/04/2026 12:10 AM-12:33 AM 23 Minutes
05/04/2026 4:49 AM-5:26 AM 37 Minutes
Reset (when staff answered the call pendant and turned the alert off).

Individual Service Plan (ISP) dated 04/27/2026 (summarized)
In the area of Toileting- supervision, cues, hand-on assistance
In the area of Transferring- assistance of 1

Example 2 Resident 2
Resident 2 was admitted 09/03/2025. Diagnoses

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Y3244	Continued From page 9	Y3244		

included difficulty in walking, not elsewhere classified; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and generalized muscled weakness.

Call pendant log (paper copy) dated 04/25/2026-05/042026:
Wait times exceeding 20 minutes (reset times were not displayed on the log):
04/25/2026-5:00 PM-5:26 PM 26 minutes
04/26/2026 3:11 PM-3:33 PM 22 minutes
04/27/2026 5:56 PM 6:24 PM 28 minutes
04/28/2026 9:15 AM-9:39 AM 24 minutes
04/29/2026 1:01 AM 1:27 AM 26 minutes
05/01/2026 7:35 PM-7:57 PM 22 minutes
05/03/2026 7:09 PM-7:31 PM 22 minutes
05/04/2026 11:53 AM-12:19 PM 26 minutes

ISP dated 03/16/2026 (summarized):
In the area of Dressing/Undressing- minimal assistance
In the area of Toileting- regular or frequent assistance to/from bathroom
In the area of Medications- history of pay, may use as needed pain medication
In the area of Mobility- requires assistance " ...helper must be present ..."

On 05/05/2026 at 10:22 AM, Surveyor interviewed Resident 1 who stated s/he often waited long times for call pendant to be answered. Resident 1 stated in January 2026 staff forgot to turn the oxygen concentrator on.

On 05/05/2026 at 10:37 AM, Surveyor interviewed Resident 2 who stated s/he experienced long call pendant wait times especially on weekends, and on occasion up to 2 hours. Resident 2 stated s/he activated the call pendant when needing to use bathroom and was

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Y3244	Continued From page 10	Y3244		

embarrassed if s/he wet him/herself.

On 05/05/2026 at 11:57 AM, Surveyor interviewed Nurse Supervisor A who stated when a resident activates their call pendant, a signal is transmitted to outside company 1, company 1 transmits a notification to company 2, then company 2 transmits notification to staff's phones. Nurse Supervisor A stated company 1 and company 2 are not in sync with each other. Nurse Supervisor A stated additionally the call pendant alerts are sent to the wrong zones on the facility campus, for example the alert for a CBRF call pendant might be sent to a staff phone at the residential care apartment complex (RCAC). Nurse Supervisor A stated these issues resulted in long call pendant wait times and has been problematic for the past 6-7 months. Nurse Supervisor A stated when viewing the call pendant logs on the computer, sometimes the call pendants were not reset for hours or even days so s/he did not provide paper copy of the entire log to Surveyor.

On 05/05/2026 at 2:35 PM, Surveyor interviewed Assistant Administrator C who stated on 02/02/2026 s/he entered a reminder in the MAR to ensure Resident 1's oxygen was on at bedtime and moved the oxygen concentrator closer to the bed. Assistant Administrator C stated the caregiver said s/he forgot to apply the oxygen because s/he was overwhelmed.

On 05/05/2026 at approximately 3:00 PM, Surveyor discussed concern with Administrator B, Assistant Administrator C and Nurse Supervisor A. Nurse Supervisor A stated they did not know what times the call pendants were reset because if reset incorrectly, they would continue to alert but the alert would not show up on staff's phones, and it was hard to know how long it took for staff

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Y3244	Continued From page 11 to respond. Nurse Supervisor A stated on or around 04/21/2026, Resident 2 expressed concern to him/her regarding long wait time, so s/he called the 2 companies. Administrator B stated they were actively working on the problem, the system and log were unreliable, and the logs could be 100 pages each day. Assistant Administrator A stated the caregiver who forgot to apply Resident 1's oxygen was a new staff and had returned to Resident 1's room to apply the oxygen within 20 minutes.	Y3244		