| 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 _____ | R-C 10/22/2024 |

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

| (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<br><br>On 10/15/2024 and 10/16/2024, Surveyor conducted 1 verification visit and 1 complaint investigation.<br><br>Ten deficiencies were identified.<br><br>Four of 10 deficiencies were repeat violations. See Statement Of Deficiency XDGS11, dated 05/31/2024.<br><br>One of 6 deficiencies from Statement Of Deficiency XDGS11, dated 05/231/2024 was substantially corrected.<br><br>The complaint was substantiated.<br><br>Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 38 | {N 000} | | |
| {N 161} | 83.12(3)(a) Investigate injuries of unknown source.<br><br>Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an investigation was completed to determine the cause of injury when an injury not observed by any person, the source of injury could not be explained by the resident | {N 161} | | |

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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019675 | A. BUILDING: _____ B. WING _____ | R-C 10/22/2024 |

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

| (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 161} | Continued From page 1 | {N 161} | | |

and the injury appeared suspicious because of the extent and location of the injury occurred.

An investigation was not completed for a bruise of unknown origin was found on Resident 1's right check.

Findings include:

On 09/19/2024, the Department received a complaint regarding an injury. On 10/15/2024 and 10/16/2024, Surveyor conducted an onsite investigation.

On 10/15/2024 at approximately 9:50 AM, Surveyor requested all incident reports including assessments and investigations since 08/01/2024 from Manager T.

On 10/15/2024 and 10/16/2024, Surveyor reviewed Resident 1's record. S/he was admitted 03/11/2024. Diagnoses included unspecified dementia.

No assessment or investigation of a fall or bruise on Resident 1's right cheek in September 2024 was provided by Manager T or documented in Resident 1's record.

On 10/16/2024 at 11:12 AM, Surveyor interviewed Manager T who stated on Friday 09/27/2024 s/he received a text message from a caregiver that Resident 1 was found sitting on his/her bedroom floor and Manager T requested the caregiver complete an incident report. Manager T stated on Monday 09/30/2024 s/he observed a bruise on Resident 1's cheek and Resident 1 was unable to tell Manager T how the bruise occurred. Manager T stated s/he assumed Resident 1 had fallen, there was no witness to confirm s/he had fallen

| 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 _____ | R-C 10/22/2024 |

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

| (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 161} | Continued From page 2<br>and no fall assessment or investigation of injury of unknown source was completed.<br><br>On 10/19/2024, Surveyor interviewed Family Member U who stated on 09/27/2024 or 09/29/2024 s/he observed a bruise the size of a 50-cent piece on Resident 1's right cheek. Family Member U stated Resident 1 told him/her s/he had walked into a wall. Family Member U stated Resident 1 was forgetful.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of no investigation for injury of unknown source with Manager T and Nurse Consultant B. Manager T stated it was unclear when bruise on Resident 1's right cheek occurred.<br><br>Cross Reference:<br>N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes | {N 161} | | |
| {N 169} | 83.12(5)(a) Notification: incident, injury, changes.<br><br>The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not immediately notify the resident's | {N 169} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 169} | Continued From page 3 | {N 169} | | |

legal representative or the resident's physician when there was an incident or injury to the resident or a significant change in the resident's physical or mental condition.

Resident 1's Power of Attorney for Health Care Agent (POA-HC) was not immediately notified of a bruise on Resident 1's right cheek.

Findings include:

On 09/19/2024, the Department received a complaint regarding an injury. On 10/15/2024 and 10/16/2024, Surveyor conducted an onsite investigation.

On 10/15/2024 and 10/16/2024, Surveyor reviewed Resident 1's record. S/he was admitted 03/11/2024. Diagnoses included unspecified dementia. Family Member U was listed on the face sheet as responsible party. On 10/19/2024 at 10:35 AM, Surveyor received an email with Resident 1's POA-HC activation form (signed 11/29/2023) attached from Executive Director E.

The record did not contain documentation of a bruise on Resident 1's right cheek or any notification of the bruise to anyone including Family Member U or Resident 1's physician.

On 10/16/2024 at 11:12 AM, Surveyor interviewed Manager T who stated on Friday 09/27/2024 s/he received a text message from a caregiver that Resident 1 was found sitting on his/her bedroom floor and Manager T requested the caregiver complete an incident report. Manager T stated on Monday 09/30/2024 s/he observed a bruise on Resident 1's cheek and Resident 1 was unable to tell Manager T how the bruise occurred. Manager T stated s/he assumed Resident 1 had fallen,

| 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 _____ | R-C 10/22/2024 |

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

| (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 169} | Continued From page 4<br>there was no witness to confirm s/he had fallen and no fall assessment or investigation of injury of unknown source completed.<br><br>On 10/19/2024 at 9:11 AM, Surveyor interviewed Family Member U who stated on 09/27/2024 or 09/29/2024 s/he observed a bruise the size of a 50-cent piece of Resident 1's right cheek. Family Member U stated staff had not notified him/her of the bruise.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of no notification of the bruise to Family Member U or Resident 1's physician with Manager T and Nurse Consultant B. Manager T stated it was unclear when bruise on Resident 1's right cheek occurred.<br><br>Cross Reference:<br>N0161 DHS 83.12(3)(a) Investigate Injuries Of Unknown Source | {N 169} | | |
| {N 352} | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the resident right to receive all prescribed medications in the dosage and at intervals prescribed by the practitioner. | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 5<br><br>From 10/04/2024 to 10/14/2024, 5 of 6 residents reviewed did not receive all prescribed medications as ordered by the practitioner.<br><br>This is a repeat deficiency. See Statement Of Deficiency (SOD) XDGS11, dated 05/31/2024.<br><br>Findings include:<br><br>The facility is licensed as a Class CNA non-ambulatory CBRF able to serve up to 48 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, advanced age, and terminally ill.<br><br>On 10/15/2024 at 2:24 PM, Surveyor inspected the Michigan East unit's medication cart with Resident Aid X and Manager T. Medications were packaged in bubble packs containing individually sealed doses (slots) of medication. On 05/16/2024, Surveyor reviewed Resident 7's, Resident 6's, Resident 9's, Resident 10's, and Resident 2's records.<br><br>Example 1-Resident 7<br>Resident 7 was admitted 02/01/2019. Diagnoses included essential (primary) hypertension.<br><br>Physician orders included carvedilol 6.25 MG 1 tablet twice daily, hold for blood pressure reading 90/50 or less.<br><br>Individual Service Plan (ISP) (dated 09/04/2024): In the area of Medications- " ...Will be supported to take all medications safely and as ordered. Date Initiated: 07/27/2023 ...Needs help with medications due to cognitive loss ..."<br><br>Bubble pack pharmacy label identified:<br>HS (hour of sleep) | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 6<br>Dispensed 10/01/2024 (date bubble pack delivered from pharmacy).<br>Start date 10/04/2024 (date administration from bubble pack starts).<br>Carvedilol 6.25 MG tablet 1 tablet twice daily<br><br>One tablet remained in 10/08/2024, 10/09/2024 and 10/10/2024 slots (Photo 7).<br><br>October 2024 Medication Administration Record (MAR): Carvedilol- On 10/08/2024, 10/09/2024 and 10/10/2024 staff documented administered.<br><br>Example 2-Resident 6<br>Resident 6 was admitted 01/31/2022. Diagnoses included hypertensive heart and chronic kidney disease with heart failure, atherosclerotic heart disease, unspecified diastolic (congestive) heart failure and dementia.<br><br>Physician orders included carvedilol 6.26 MG 1 tablet twice daily with meals (start date 08/21/2024) and pantoprazole 40 MG 1 tablet twice daily (start date 08/21/2024).<br><br>ISP (dated 02/29/2024): In the area of Medications- " ...Will be supported to take all medications safely and as ordered. Date Initiated: 07/27/2023 ...Needs help with medications due to cognitive loss ..."<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Pantoprazole 40 MG 1 tablet twice daily<br><br>One tablet remained in the 10/09/2024 slot (Photo 8) | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 7<br><br>October 2024 MAR: Pantoprazole- On 10/09/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Carvedilol 6.26 MG 1 tablet twice daily<br><br>One tablet remained in the 10/06/2024 slot (Photo 9)<br><br>October 2024 MAR: Carvedilol- On 10/06/2024 staff documented administered.<br><br>Example 3- Resident 9<br>Resident 9 was admitted 04/03/2024. Diagnoses included: Systemic sclerosis; Parkinson's disease without dyskinesia; hypothyroidism; hypertensive heart and chronic kidney disease with heart failure; anxiety disorder; essential tremor; major depressive disorder, recurrent; and unspecified dementia.<br><br>Physician orders included: Pantoprazole 40 MG 1 tablet twice daily (start date 04/06/2024); buspirone 15 MG 1 tablet 3 times daily (start date 04/18/2024); sucralfate 1 GM 1 tablet twice daily (start date 04/06/2024); pentoxifylli 400 MG ER 1 tablet 3 times daily with meals (start date 04/06/2024); levetiraceta 500 MG 1 tablet twice daily (start date 04/06/2024); propranolol 10 MG 1 tablet twice daily (start date 04/06/2024); primidone 50 MG 2 tablets 3 times daily (04/06/2024); F&T Cranberry 500 MG 1 tablet at bedtime (04/06/2024); melatonin 10 MG Q/D 1 tablet at bedtime (start date 04/06/2024); quetiapine 25 MG 1 tablet at bedtime (start date 09/03/2024); pramipexole 0.5 MG 1 tablet 3 times daily (start date 04/06/2024); and diclofenac 75 | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 8<br>MG 1 tablet by mouth twice daily (start date 04/06/2024).<br><br>ISP (dated 04/11/2024): In the area of Medications- " ...Will be supported to take all medications safely and as ordered. Date Initiated: 04/11/2024 ...Needs help with medications due to cognitive loss ..."<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Pantoprazole 40 MG 1 tablet twice daily<br><br>One tablet remained in the 10/08/2024, 10/09/2024, 10/11/2024 and 10/12/2024 slots (Photo 10).<br><br>October 2022 MAR: Pantoprazole -A total of 2 rows were labeled 8:00 AM and 5:00 PM. There was no documentation in the 5:00 PM row on 10/08/2024 or 10/09/2024, and on 10/11/2024 and 10/12/2024 staff documented administered in the 5:00 PM row.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Buspirone 15 MG 1 tablet 3 times daily<br><br>One tablet remained in the 10/08/2024, 10/09/2024, 10/10/2024 and 10/12/2024 slots (Photo 11).<br><br>October 2024 MAR: Buspirone - A total of 3 rows were labeled 8:00 AM, 1:00 PM and 6:00 PM. There was no documentation in the 6:00 PM row on 10/08/2024, 10/09/2024, 10/10/2024 or | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 9<br>10/12/2024.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Sucralfate 1 GM 1 tablet twice daily.<br><br>One tablet remained in 10/08/2024, 10/09/2024, 10/10/2024 and 10/11/2024 slots (Photo 12)<br><br>October 2024 MAR: Sucralfate- No documentation on 10/08/2024, 10/09/2024 or 10/10/2024, and on 10/11/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Pentoxifylli 400 MG ER 1 tablet 3 times daily with meals<br><br>One tablet remained in the 10/08/2024, 10/09/2024, 10/11/2024 and 10/12/2024 slots (Photo 13).<br><br>October 2024 MAR: Pentoxifylli- A total of 3 rows labeled 8:00 AM, 1:00 PM and 6:00 PM. There was no documentation in 6:00 PM row 10/08/2024 or 10/09/2024, and on 10/11/2024 and 10/12/2024 staff documented administered in the 6:00 PM row.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Levetiraceta 500 MG 1 tablet twice daily | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 10<br>One tablet remained in 10/08/2024, 10/09/2024, 10/11/2024 and 10/12 204 slots (Photo 14).<br><br>October 2024 MAR: Levetiraceta- A total of 2 rows labeled 8:00 AM and 5:00 PM. There was no documentation in 5:00 PM row 10/08/2024 or 10/09/2024, and on 10/11/2024 and 10/12/2024 staff documented administered in the 5:00 PM row.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Propranolol 10 MG 1 tablet twice daily<br><br>One tablet remained in the 10/08/2024, 10/09/2024, 10/10/2024, 10/11/2024 and 10/12/2024 slots (Photo 15).<br><br>October 2024 MAR: Propranolol- No documentation 10/08/2024, 10/09/2024 or 10/10/2024, and on 10/11/2024 and 10/12/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Primidone 50 MG 2 tablets 3 times daily<br><br>Two tablets remained in the 10/08/2024, 10/09/2024, 10/11/2024 and 10/12/2024 slots (Photo 16).<br><br>October 2024 MAR: Primidone- A total of 3 rows labeled 8:00 AM, 1:00 PM and 6:00 PM. There was no documentation in the 6:00 PM row 10/08/2024 or 10/09/2024, and on 10/11/2024 and 10/12/2024 staff documented administered in | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 11<br>the 6:00 PM row.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>F&T Cranberry 500 MG 1 tablet at bedtime<br><br>One tablet remained in the 10/08/2024 and 10/09/2024 slots (Photo 17)<br><br>October 2024 MAR: Cranberry- There was no documentation on 10/08/2024 or 10/09/2024.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Melatonin 10 MG Q/D 1 tablet at bedtime<br><br>One tablet remained in the 10/08/2024 and 10/09/2024 slots (Photo 18).<br><br>October 2024 MAR: Melatonin- There was no documentation on 10/08/2024 or 10/09/2024.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Quetiapine 25 MG 1 tablet at bedtime<br><br>One tablet remained in the 10/04/2024, 10/05/2024, 10/06/2024, 10/07/2024, 10/08/2024, and 10/09/2024 slots (Photo 19).<br><br>October 2024 MAR: Quetiapine- There was no documentation on 10/04/2024, 10/07/2024, 10/08/2024, or 10/09/2024, on 10/05/2024 staff coded "16" (medication unavailable), and on | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 12<br>10/06/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Pramipexole 0.5 MG 1 tablet 3 times daily<br><br>One tablet remained in 10/08/2024, 10/09/2024, 10/10/2024, 10/12/2024 and 10/14/2024 slots (Photo 20).<br><br>October 2024 MAR: Pramipexole-There were 3 rows labeled 8:00 AM, 1:00 PM and 6:00 PM. There was no documentation on 10/08/2024, 10/09/2024, and 10/10/2024 in the 6:00 PM row, and on 10/12/2024 and 10/14/2024 staff documented administered in the 6:00 PM row.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Diclofenac 75 MG 1 tablet by mouth twice daily<br><br>One tablet remained in 10/08/2024, 10/09/2024, 10/10/2024 and 10/11/2024 slots (Photo 21).<br><br>October 2024 MAR: Diclofenac- No documentation 10/08/2024, 10/09/2024, or 10/10/2024, and on 10/11/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Baclofen 10 MG 1 tablet twice daily<br><br>One tablet remained in 10/08/2024, 10/09/2024 | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 13<br>and 10/12/2024 slots (Photo 22).<br><br>October 2024 MAR: Baclofen- No documentation on 10/08/2024 and 10/09/2024, and on 10/12/2024 staff documented administered.<br><br>Example 4- Resident 10<br>Resident 10 was admitted 08/22/2024. Diagnoses included: hyperlipidemia, unspecified; Alzheimer's disease, unspecified; other seizures; paroxysmal atrial fibrillation; and type II diabetes.<br><br>Physician orders included: primidone 50 MG 2 tablets once daily with dinner (start date 08/22/2024); gabapentin 300 MG 1 capsule 3 times daily (start date 09/18/2024); atorvastatin 20 MG 1 tablet at bedtime (start date 09/18/2024); donepezil 10 MG 1 tablet at bedtime (start date 09/18/2024); metformin 500 MG 1 tablet twice daily with meals (start date 08/22/2024); metoprolol SUC 25 MG ER 1 half tablet daily at bedtime (start date 08/22/2024); glimepiride 2 MG 1 tablet twice daily (start date 09/18/2024); and levetiraceta 500 MG 1 tablet twice daily (start date 09/19/2024).<br><br>ISP (dated 08/22/2024): In the area of Medications- " ...Will be supported to take all medications safely and as ordered. Date Initiated: 08/22/2024 ...Needs help with medications due to cognitive loss ..."<br><br>Bubble pack pharmacy label identified:<br>PM<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Primidone 50 MG 2 tablets once daily with dinner<br><br>Two tablets remained in slots 10/11/2024, 10/12/2024, 10/13/2024 and 10/14/2024 (Photo | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 14<br>23).<br><br>October 2024 MAR: Primidone- Total of 1 row labeled AM. On 10/11/2024 staff coded "16" (medication unavailable) and on 10/12/2024, 10/13/2024 and 10/14/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Gabapentin 300 MG 1 capsule 3 times daily<br><br>One capsule remained in 10/11/2024, 10/12/2024, 10/13/2024 and 10/14/2024 (Photo 24)<br><br>October 2024 MAR: Gabapentin- No documentation on 10/13/2024, and on 10/11/2024, 10/12/2024, and 10/14/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Atorvastatin 20 MG 1 tablet at bedtime<br><br>One tablet remained in 10/12/2024 and 10/13/2024 slots (Photo 25).<br><br>October 2024 MAR: Atorvastatin- No documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024. | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 15<br>Donepezil 10 MG 1 tablet at bedtime<br><br>One tablet remained in 10/12/2024 and 10/13/2024 slots (Photo 26).<br><br>October 2024 MAR: Donepezil - No documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Metformin 500 MG 1 tablet twice daily with meals<br><br>One tablet remained in 10/12/2024 and 10/13/2024 slots (Photo 27).<br><br>October 2024 MAR: Metformin- no documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>Bedtime<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Metoprolol SUC 25 MG ER 1 half tablet daily at bedtime.<br><br>One half tablet remained in 12/12/2024 and 10/13/2024 slots (Photo 28).<br><br>October 2024 MAR: Metformin- No documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024. | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 16<br>Glimepiride 2 MG 1 tablet twice daily<br><br>One tablet remained in 10/12/2024 and 10/13/2024 slots (Photo 29).<br><br>October 2024 MAR: Glimepiride- No documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Levetiraceta 500 MG 1 tablet twice daily<br><br>One tablet remained in 10/12/2024 and 10/13/2024 slots (Photo 30).<br><br>October 2024 MAR: Levetiraceta - No documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>Example 5- Resident 2<br>Resident 2 was admitted 04/01/2024. Diagnoses included: Alzheimer's disease with late onset; and major depressive disorder, recurrent, mild.<br><br>Physician orders included trazadone 50 MG ½ tablet (25 MG) twice daily. There was no order for memantine HCL 10 MG 1 tablet twice daily.<br><br>ISP (not signed or dated): In the area of Medications- " ...Will be supported to take all medications safely and as ordered. Date Initiated: 04/12/2024 ...Needs help with medications due to cognitive loss ..."<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024. | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 17<br>Start date 10/04/2024.<br>Memantine HCL 10 MG 1 tablet twice daily<br><br>Bubble pack slots dated 10/4/2024, 10/05/2024, 10/06/2024, 10/07/2024, 10/08/2024 and10/09/2024 were empty. One tablet remained in the bubble pack slots dated 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024 and 10/14/2024 (Photo 33).<br><br>October 2024 MAR did not include memantine. Memantine was not listed with active medications in psychiatric visit note dated 10/03/2024 or on hospice medication profile when Resident 2 was admitted onto hospice service 10/08/2024.<br><br>Bubble pack pharmacy label identified:<br>HS<br>Dispensed 10/01/2024.<br>Start date 10/04/2024.<br>Trazadone 50 MG 1 half tablet twice daily.<br><br>One half tablet remained in 10/12/2024 and 10/13/2024 slots (Photo 31).<br><br>October 2024 MAR: Trazadone- No documentation on 10/13/2024, and on 10/12/2024 staff documented administered.<br><br>On 10/15/2024, Surveyor, Manager T and Nurse Consultant B listed medications left in bubble packs 10/04/2024-10/14/2024. 10/16/2024 at approximately 9:15 AM, Manager T stated s/he had audited medications and Resident 2's memantine physician order was discontinued on 09/24/2024 but staff administered it 10/04/2024 to 10/09/2024.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of medications not | {N 352} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 352} | Continued From page 18<br>administered as ordered by the practitioner with Nurse Consultant B and Manager T. Nurse Consultant B stated s/he found no documentation in the resident records explaining why medications remained in the bubble packs. Nurse Consultant B stated they would investigate how the breakdown occurred.<br><br>On 10/25/2024 at 11:50 AM, Surveyor interviewed Pharmacy Data Entry Tech Y who stated Resident 2's physician order for memantine was not discontinued but the prescription refill expired 09/18/2024. Pharmacy Data Entry Tech Y stated the new renewal request was received by pharmacy on 10/01/2024 and it was dispensed 10/01/2024.<br><br>On 10/24/2024 at 2:57 PM, Surveyor emailed Nurse Consultant B, Manager T and Executive Director V asking if Resident 9 had bubble packs labeled PM, 5 PM, 6 PM or "evening", etc. that staff were administering from to explain why medications were left in the HS bubble packs. Surveyor requested a reply by 3:00 PM on 10/25/2024, and as of 4:45 PM on 10/25/2024 no reply was received.<br><br>Cross Reference:<br>N0415 DHS 83.37(2)(d) Documentation Of Medication Administration | {N 352} | | |
| {N 356} | 83.32(3)(l) Rights of Residents: Least restrictive env<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The | {N 356} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 356} | Continued From page 19<br>CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice.<br><br>This Rule is not met as evidenced by:<br>Based on interview and observation the provider did not ensure rules or other restrictions did not interfere with the resident's freedom of choice.<br><br>Resident's freedom of choice was restricted when window cranks were removed from their windows and their individual service plans (ISP) did not address the restriction.<br><br>Thirty-two of 38 residents did not have room keys. Verbal assessments regarding ability to manage room keys were conducted with activated Power of Attorney for Health Care (POA-HC) agents and the resident's ISPs did not address the restriction.<br><br>Findings include:<br><br>On 09/19/2024, the Department received a complaint regarding unopenable windows and resident room keys.<br><br>The facility is licensed as a Class CNA non-ambulatory CBRF able to serve up to 48 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, advanced age, and terminally ill.<br><br>On 10/15/2024 and 10/16/2024, Surveyor conducted a complaint investigation.<br><br>Example 1- Window cranks<br>Each resident room had 2 side by side casement | {N 356} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 356} | Continued From page 20<br>style windows and each window had its own crank to open/close it.<br><br>On 10/15/2024, Surveyor observed both window cranks missing from resident's windows: 10:34 AM- Resident 2<br>10:36 AM- Resident 6 (Photo 6)<br>10:37 AM- Resident 11<br>10:56 AM- Resident 1<br><br>On 10/15/2024 at 11:06 AM, while touring facility with Nurse Consultant B, Surveyor observed both window cranks were missing from resident windows:<br>Resident 7<br>Resident 8<br>Resident 9<br>Resident 10<br><br>On 10/15/2024 at 10:55 AM, Surveyor interviewed Resident 1 who stated his/her window cranks had been removed from the window near end of summer 2024 but s/he did not why.<br><br>On 10/15/2024 at 11:15 AM, Surveyor interviewed Manager T who stated window cranks were removed from windows after Resident 11 broke a partially open window and eloped through the window during the first week of September 2024. Manager T stated the cranks were put on the permanent wall shelves in each room and s/he had an extra crank in his/her office.<br><br>On 10/16/2024 at 10:33 AM, Surveyor observed the permanent shelf in Resident 2's room was approximately 7 feet from the floor.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of unopenable windows Manager T and Nurse Consultant B. | {N 356} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 356} | Continued From page 21<br><br>Manager T stated the cranks were removed from the windows the 2nd or 3rd week of September. Manager T stated removal of window cranks was not identified on resident's ISP's because it was an immediate but not a long-term intervention.<br><br>Example 2- Resident room keys<br>On 10/15/2024 at 11:20 AM, Surveyor observed Resident 9 enter the dining room and ask Resident Aid Z to unlock his/her room door. Resident Aid Z stated s/he would need to get the key from Resident Aid P. Approximately 5 minutes later, Surveyor observed Resident 9 and Resident Aid Z in the hall by Resident 9's room. Resident Aid Z unlocked Resident 9's room door and Resident 9 entered his/her room.<br><br>On 10/15/2024 at 11:25 AM, Surveyor interviewed Resident 9 who stated his/her room door was locked anytime s/he was out of the room due to other residents going in his/her room. Resident 9 stated when s/he asked for a key s/he was told "No." Resident 9 stated s/he was frustrated that s/he could not get into his/her room without looking for someone to unlock it.<br><br>On 10/15/2024 at 10:55 AM, Surveyor interviewed Resident 1 who stated s/he did not have a key to his/her room until Family Member U recently had a key made. Resident 1 stated Resident 2 would enter his/her room and laid on the bed which s/he did not like.<br><br>On 10/15/2024 at 10:50 AM, Surveyor interviewed Resident Aid P who stated most residents wanted their doors kept locked and some had keys. Resident Aid P stated the master key was on the medication room key ring.<br><br>On 10/16/2024 at 11:12 AM, Surveyor interviewed | {N 356} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 356} | Continued From page 22 | {N 356} | | |

Manager T who stated 6 (of 38) residents had keys and standard practice was to not issue room keys unless the resident's POA-HC agent requested one. Manager T stated resident assessments to manage room keys were conducted verbally mainly with POA-HC agents and ISPs were not updated for residents who could not manage a key and not issued a key. Manager T stated admission agreements did not address room keys. Manager T stated Resident 13 did not have a room key or an activated POA-HC agent.

On 10/16/2024 at 11:31 AM, Surveyor observed Resident 13 and Resident Aid W in the hall at Resident 13's room. Resident Aid W unlocked Resident 13's door and Resident 13 entered his/her room.

On 10/16/2024 at 11:31 AM, Surveyor interviewed Resident 13 who stated s/he did not have a room key but wanted one so s/he would not have to bother staff to unlock his/her door every time s/he wanted to enter his/her room. Resident 13 stated s/he heard some residents had keys but s/he was not asked if s/he wanted one. Resident 13 stated Resident 16 entered his/her room and made a mess in the bathroom so s/he wanted to lock his/her door to keep Resident 16 out.

On 10/15/2024, Surveyor received a list of residents having room keys from Manager T. Residents 1, 14, 17,18, 19 and 20 were listed.

On 10/15/2024, Surveyor reviewed individual service plans (ISP's) of Resident 1 (not dated), Resident 2 (not dated), Resident 6 (dated 02/29/2024), Resident 7 (dated 09/04/2024), Resident 8 (dated 08/19/2024), Resident 9 (dated 04/11/2024), Resident 10 (dated 08/22/2024), and

| 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 _____ | R-C 10/22/2024 |

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

| (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 356} | Continued From page 23<br><br>Resident 11 (dated 08/19/2024). Withheld window cranks were not addressed in their ISP's. Withheld room keys were not addressed in Resident 2's, Resident 6's, Resident 7's, Resident 8's, Resident 9's, Resident 10's, or Resident 11's ISPs.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of window cranks and room keys with Manager T and Nurse Consultant B. Nurse Consultant B stated they would issue Resident 13 a key on 10/16/2024.<br><br>On 10/19/2024 at 9:11 AM, Surveyor interviewed Family Member U who stated approximately 2 months prior (to 10/19/2024) s/he noticed the window cranks were missing from Resident 1's window. Family Member U stated Manager T told him/her the cranks were on the permanent wall shelf in Resident 1's room but because the shelf was so high Family Member U stood on a chair but did not find the cranks. Family Member U stated Resident 1 enjoyed his/her window open on nice days. Family Member U stated Resident 1 was admitted in March 2024 but not issued a room key until approximately 10/10/2024 when Family Member U requested one and prior to that during his/her visits, s/he had to find staff to unlock Resident 1's door multiple times including a couple times when s/he went other side of the unit to find staff. Family Member U stated Resident 1 was forgetful but able to use a key.<br><br>Cross Reference:<br>N0668 DHS 83.61(1) Total/Openable Window Area | {N 356} | | |
| {N 387} | 83.35(3)(b) Service plan development: parties involved | {N 387} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 387} | Continued From page 24<br><br>Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the resident or resident's legal representative signed the individual service plan (ISP) acknowledging their involvement in, understanding of and agreement with the plan for 8 of 9 residents reviewed.<br><br>This is a repeat deficiency. See Statement Of Deficiency (SOD) XDGS11, dated 05/31/2024.<br><br>Findings include:<br><br>On 10/15/2024, Surveyor requested Resident 1's, Resident 2's, Resident 6's, Resident 7's, Resident 8's, Resident 9's, Resident 10's, Resident 11's and Resident 12's records including ISP signature sheets from Manager T. On 10/24/2024 at 11:40 AM and 10/24/2024 3:55 PM Surveyor received | {N 387} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 387} | Continued From page 25<br>Power of Attorney for Health Care (POA-HC) activation forms from Manager T.<br><br>Example 1- Resident 2<br>Resident 2 was admitted 04/01/2024. His/her POA-HC document was activated 12/11/2020 and his/her ISP (not dated) was not signed.<br><br>Example 2- Resident 6<br>Resident 6 was admitted 01/31/2022. His/her POA-HC document was activated 12/24/2021 and his/her ISP (dated 02/29/2024) was not signed.<br><br>Example 3- Resident 7<br>Resident 7 was admitted 02/01/2019. His/her POA-HC document was activated 03/20/2019 and his/her ISP (09/04/2024) was not signed.<br><br>Example 4- Resident 8<br>Resident 8 was admitted 08/19/2024. His/her POA-HC document was activated 08/01/2024 and his/her ISP (08/19/2024) was not signed.<br><br>Example 5- Resident 9<br>Resident 9 was admitted 04/03/2024. His/her face sheet indicated s/he had an activated POA-HC agent. His/her ISP (04/11/2024) was not signed.<br><br>Example 6- Resident 10<br>Resident 10 was admitted 08/22/2024. His/her POA-HC document was activated 03/03/2022 and his/her ISP (dated 08/19/2024) was not signed.<br><br>Example 7- Resident 11<br>Resident 11 was admitted 03/11/2024. His/her POA-HC document was activated 08/02/2024 and his/her ISP (dated 08/19/2024) was not | {N 387} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 387} | Continued From page 26<br>signed.<br><br>Example 8- Resident 12<br>Resident 12 was admitted 05/22/2024. His/her POA-HC document was activated 05/08/2020 and his/her ISP (dated 05/22/2024) was not signed.<br><br>On 10/16/2024 at 10:22 AM, Surveyor interviewed Manager T who stated Resident 10, Resident 11, and Resident 8 were new residents so their ISP reviews were not yet due, Resident 6's ISP review was due, Resident 9's ISP review was scheduled, Resident 12's ISP review was coming due, and s/he could not find ISP signature sheet for Resident 7.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of unsigned ISPs with Manager T and Nurse Consultant B. Manager T stated the POA-HC agents worked full time and preferred to review ISPs in person.<br><br>Cross Reference:<br>N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan | {N 387} | | |
| {N 388} | 83.35(3)(c) Implement, follow the individual service plan<br><br>Implementation. The CBRF shall implement and follow the individual service plan as written.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure individual service plans was followed as written for 2 of 2 residents reviewed. | {N 388} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 388} | Continued From page 27<br>This is a repeat deficiency. See Statement Of Deficiency (SOD) XDGS11, dated 05/31/2024.<br><br>On 10/15/2024 and 10/16/2024, Surveyor conducted a verification visit.<br><br>Example 1- Resident 2<br>On 10/15/2024 at 10:43 AM, Surveyor was approached by Resident 2 in the hallway who stated s/he could not find his/her glasses and could not see well without them. Surveyor accompanied Resident 2 to his/her room and when s/he was unable to find his/her glasses s/he requested Surveyor look in the bedside table's drawer. When Surveyor informed Resident 2 the glasses were not in the drawer, Resident 2 said "I need glasses bad. They're not cheap. I can't afford to lose them. I'll lay down in bed and hope for the best." Resident 2 laid down on bed.<br><br>On 10/15/2024 at 10:50 AM, Surveyor interviewed Resident Aid P who stated when s/he got Resident 2 ready for the day at 8:00 AM s/he looked for his/her glass but did not see them.<br><br>On 10/15/2024 at 11:10 AM, Resident Aid P informed Surveyor s/he had just found Resident 2's glasses in the common room.<br><br>On 10/15/2024, Surveyor reviewed Resident 2's record. S/he was admitted 04/01/2024.<br>ISP (not dated or signed):<br>In the area of Vision- " ...Will be supported to maintain appropriate assistive devices for vision ...Ensure glasses are on and that the glasses are clean (Date Initiated: 07/31/2024) ..."<br><br>Example 2- Resident 12<br>On 10/15/2024 at 11:50 AM, Surveyor observed Resident 12 in the dining room. His/her hair was | {N 388} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 388} | Continued From page 28<br>uncombed, and whiskers overgrown including approximately 2" on upper cheeks by ears.<br><br>On 10/15/2024 at 11:50 AM, Surveyor interviewed Resident Aid W who stated Resident 12 resisted cares 10/15/2024 AM. Resident Aid W stated Resident 12's acceptance of cares varied.<br><br>On 10/15/2024, Surveyor reviewed Resident 12's record. S/he was admitted 05/22/2024.<br>ISP (dated 05/22/2024):<br>In the area of Grooming/Oral Hygiene- "<br>...Requires assistance with grooming needs (Date Initiated: 05/22/2024).<br><br>On 10/16 2024 at 10:10 AM, Surveyor observed Resident 12 in the living room. Resident 12 was unshaven, and hair was uncombed. Surveyor interviewed Resident 12 who stated s/he did not normally have a beard.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of ISPs not implemented as written with Manager T and Nurse Consultant B. Manager T stated Resident 12 received haircuts and shaves by beautician, but beautician was not there last week. Nurse Consultant B stated they would offer to shave Resident 12 on 10/16/2024. Nurse Consultant B stated Resident 2's family had 2 pair of backup glasses and on 10/16/2024 they requested a neck string for Resident 2's glasses from activities staff.<br><br>Cross Reference:<br>N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved | {N 388} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 415 | Continued From page 29 | N 415 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure at the time of medication administration staff documented in the resident record the date and time of medication administration for 2 of 3 residents reviewed.<br><br>From 10/01/2024 - 10/14 2024, staff failed to document administration of scheduled physician ordered medications 8 times for Resident 2 and 42 times for Resident 10.<br><br>Findings include:<br><br>On 10/15/2024, Surveyor reviewed Resident 2's and Resident 10's records.<br><br>Example 1- Resident 2<br>Resident 2 was admitted 04/01/2024.<br>Physician orders included trazadone 50 MG ½ tablet (25 MG) twice daily (start date: 09/18/2024) and acetaminophen 500 MG 2 tablets twice daily. | N 415 | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 415 | Continued From page 30<br><br>Medication Administration Record (MAR) dated 10/01/2024-10/14/2024:<br>Staff did not document administration of (HS) Trazadone- 10/01/2024; 10/02/2024; 10/03/2024; 10/04/2024; 10/07/2024; 10/08/2024; 10/09/2024; or 10/10/2024.<br><br>Example 2 - Resident 10<br>Resident 10 was admitted 08/22/2024.<br>Physician orders included: primidone 50 MG 2 tablets once daily with dinner (start date 08/22/2024); atorvastatin 20 MG 1 tablet at bedtime (start date 09/18/2024); donepezil 10 MG 1 tablet at bedtime (start date 09/18/2024); metformin 500 MG 1 tablet twice daily with meals (start date 08/22/2024); metoprolol SUC 25 MG ER 1 half tablet daily at bedtime (start date 08/22/2024); glimepiride 2 MG 1 tablet twice daily (start date 09/18/2024); and levetiracetam 500 MG 1 tablet twice daily (start date 09/19/2024).<br><br>Medication Administration Record (MAR) dated 10/01/2024-10/14/2024:<br>Staff did not document administration of the following scheduled medications on 10/01/2024; 10/02/2024; 10/03/2024; 10/04/2024; 10/08/2024; 10/09/2024; or 10/10/2024: (HS) atorvastatin, (HS) metoprolol, (HS) donepezil, (evening) levetiracetam, (HS) glimepiride; and (HS) metformin.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of medication documentation with Manager T and Nurse Consultant B. Nurse Consultant B stated "Okay."<br><br>Cross Reference:<br>N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication | N 415 | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 419 | 83.37(3)(c) Medication storage: locked cabinet.<br><br>Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure medications were secured properly.<br><br>Two of 2 medication room doors were left unlocked.<br><br>Michigan House East's medication room was left unattended and unlocked and the medication cart containing medications inside the medication room was unlocked.<br><br>Michigan House West's medication room was left unattended and unlocked and the refrigerator containing medications inside the medication room was unlocked.<br><br>Findings include:<br><br>The facility is licensed as a Class CNA non-ambulatory CBRF able to serve up to 48 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, advanced age, and terminally ill. The facility is divided into 2 units, Michigan House West and Michigan House East.<br><br>On 10/15/2024 at 9:40 AM, Surveyor observed the Michigan House East's medication room door open and the medication cart parked inside the medication room was unlocked (Photo 1). No staff were observed in the general vicinity of the medication room. Resident 11 was walking near | N 419 | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 419 | Continued From page 32 | N 419 | | |

the medication room.

At 9:43 AM, Resident Aid P arrived at the medication room, retrieved an item, and locked the medication room.

On 10/15/2024 at 10:14 AM, Surveyor observed the Michigan House West's medication room door open. A medication cart and mini refrigerator were in the medication room. The medication cart was locked. Surveyor opened the unlocked refrigerator and observed medications stored in the refrigerator. The medication room was approximately 25 feet from the entrance of the unit. At 10:18 AM, Surveyor observed Resident 12 leave his/her room and walk past the medication room to the living room. At 10:27 AM, Resident Aid W arrived at the medication room.

On 10/15/2024 at 10:29 AM, Surveyor interviewed and inspected the contents of Michigan House West's medication room's mini refrigerator located with Resident Aid W. Surveyor observed 1 Humalog insulin pen, 5 Lantus insulin pens, and 2 Glucagon insulin pens labeled for Resident 13 and 1 bottle of latanoprost eye drops labeled for Resident 15 stored in the refrigerator (Photo 3). Resident Aid W stated s/he knew the medication cart had to be locked but did not know the mini refrigerator had to be locked or the medication room door had to be locked if the medication cart and/or mini refrigerator were unlocked.

On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern unsecured medications with Manager T and Nurse Consultant B. Nurse Consultant B stated they would educate staff.

| 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 _____ | R-C 10/22/2024 |

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

| (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 489 | Continued From page 33 | N 489 | | |
| N 489 | 83.44(2)(a) Rooms clean and free from odors.<br><br>The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure resident rooms were clean and free from odors.<br><br>This is a repeat deficiency. See Statement Of Deficiency (SOD) XDGS11, dated 05/31/2024.<br><br>Findings include:<br><br>The facility is licensed as a Class CNA non-ambulatory CBRF able to serve up to 48 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, advanced age, and terminally ill.<br><br>On 10/15/2024, Surveyor was in Resident 2's room interviewing him/her. When Resident 2 requested Surveyor check the bedside cabinet drawer for his/her eyeglasses, Surveyor observed the drawer was empty except for 1 electric hair clipper guard and an empty soiled snack container. Orange, yellow, and clear substances were adhered to the inside of the drawer. A trash can with no bag was set on the floor next to the bedside cabinet. Dried orange and clear substances, a ketchup packet, a snack container cover and 2 other pieces of trash were in the can (Photo 4).<br><br>On 10/15/2024 at 10:50 AM, Surveyor interviewed Resident Aid P who stated the substances in Resident 2's bedside cabinet | N 489 | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 489 | Continued From page 34<br>drawer was food because brought Resident 2 junk food. Resident Aid P stated s/he did not know why the substance was in the trash can.<br><br>On 10/15/2024 at 10:55 AM while interviewing Resident 1 in his/her room, Surveyor observed several dark black stained areas within approximately an 18" x 18" area on the carpet in front of his/her recliner (Photo 5). Resident 1 stated s/he did not know how long the carpet had been soiled.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of Resident 1's carpet and Resident 2's drawer and trash can with Manager T and Nurse Consultant B. Manager T stated Resident 1's carpet was frequently extracted but they were unable to get the stains out.<br><br>On 10/16/2024, Surveyor reviewed the facility's program statement on file with the Department which stated "Our program goal is to provide the highest quality of life in a supervised setting, including ...housekeeping ..." | N 489 | | |
| {N 668} | 83.60(1) Total/openable window area<br><br>Minimum size. Every habitable room shall have at least one outside window with a total window area of at least 8% of the floor area in the room. The window shall be openable from the inside without the use of tools or keys. The openable area of the window shall be not less than 4% of the floor area of the room. | {N 668} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 668} | Continued From page 35<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure windows were openable from the inside when window cranks used to open the window were removed.<br><br>Window cranks were removed from 8 of 8 windows observed.<br><br>Findings include:<br><br>On 09/19/2024, the Department received a complaint regarding an unopenable windows.<br><br>The facility is licensed as a Class CNA non-ambulatory CBRF able to serve up to 48 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, advanced age, and terminally ill.<br><br>On 10/15/2024 and 10/16/2024, Surveyor conducted a complaint investigation.<br><br>Each resident room had 2 side by side casement style windows and each window had its own crank to open/close it.<br><br>On 10/15/2024, Surveyor observed both window cranks had been removed from resident's windows: 10:34 AM- Resident 2; 10:36 AM- Resident 6 (Photo 6); 10:37 AM- Resident 11; and 10:56 AM- Resident 1. On 10/15/2024 at 11:06 AM, while touring facility with Nurse Consultant B, Surveyor observed both window cranks removed from resident windows: Resident 7; Resident 8; Resident 9 and Resident 10.<br><br>On 10/15/2024 at 11:15 AM, Surveyor interviewed Manager T who stated window cranks were | {N 668} | | |

| 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 _____ | R-C 10/22/2024 |

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

| (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 668} | Continued From page 36<br>removed from windows after Resident 11 broke a partially open window and eloped through the window during the first week of September 2024. Manager T stated the cranks were put on the permanent wall shelves in each room and s/he had an extra crank in his/her office.<br><br>On 10/16/2024 at 10:33 AM, Surveyor observed the permanent shelf in Resident 2's room was approximately 7 feet from the floor.<br><br>On 10/16/2024 at approximately 12:00 PM, Surveyor discussed concern of unopenable windows Manager T and Nurse Consultant B. Manager T stated the cranks were removed from the windows the 2nd or 3rd week of September 2024 as an immediate but not long-term intervention. When Surveyor asked if they requested a waiver from the Department for N0668 DHS 83.61(1) Total/Openable Window Area, Manager T stated they had not.<br><br>Cross Reference:<br>N0356 DHS 83.32(3)(L) Rights Of Residents-Least Restrictive Environment | {N 668} | | |