STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525219	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Platteville	1300 N Water St Platteville, WI 53818

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, facility staff did not adequately assess and treat pain and provide necessary care and services to attain or maintain the highest practicable physical well-being for 1 of 1 resident (R1) reviewed for pain. R1 complained of pain during pericare. R1 was observed to wince and cry due to the pain. At no point during this interaction did staff stop care and let R1 take a break, or immediately notify the nurse of R1's pain. Evidenced by: The facility policy, Pain Management and Assessment, revised 4/27/22, indicates in part the following: The purpose of this policy is to develop a standardized method for assessing, monitoring, evaluating, managing, and documenting pain in both cognitively intact and impaired residents. Residents will receive necessary comfort, exercise greater independence, and enhance dignity through optimizing their ability to perform activities of daily living. Evaluate for behavioral responses to pain: a. facial wrinkling/grimacing; c. crying or moaning; g. decreased interaction. Non-pharmacological interventions (i.e. repositioning resident, turning lights off, warm cloth, etc.) will be attempted prior to the use of PRN (as needed) analgesics whenever appropriate. Use of interventions and effectiveness will be documented. R1 was admitted to the facility 4/9/24 with diagnoses including, but not limited to, spondylosis, osteoporosis, dementia, major depressive disorder single episode, total retinal detachment, occlusion and stenosis of bilateral carotid arteries, muscle wasting and atrophy. R1's Admission Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview for Mental Status (BIMS) of 13, indicating she is cognitively intact. R1's PHQ-9 indicates Minimal Depression. R1 is her own person. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Certified Nursing Assistant (CNA) Kardex documents, in part, the following: Transfer, Toileting, Bathing, Bed Mobility, Dressing assist of one (1). In addition, Toileting indicates the following interventions: Apply barrier cream to peri area after each incontinent episode; Check and change resident as needed due to incontinence; Incontinence care after each incontinent episode; Record bowel movement pattern each day. Describe amount, color, and consistency; Scheduled Toileting Program for incont (incontinent) episode at 3 hours. The section Skin indicates other pain intervention: May use lotion and water on wash clothes to remove bm more gently; offer whirlpool baths more frequently as she allows, apply barrier cream/ointment with peri care interaction, other medication cream or pads as ordered. On 7/30/24 at approximately 12:30 PM, Surveyor spoke with CNA/Scheduler C (Certified Nursing Assistant/Scheduler). Surveyor asked CNA/Scheduler C to described what occurred during her shift on 7/7/24. CNA/Scheduler C stated, she was working as 1/2 Bath Aide and 1/2 CNA. CNA/Scheduler C stated, at approximately 1:30 PM, she answered R1's call light. CNA/Scheduler C stated, When washing her up I could feel her wince and My hands are huge, and I was trying to be gentle. CNA/Scheduler C stated, she observed a tear on R1's nose. CNA/Scheduler C stated, when she could see R1 was in pain she pushed R1's call light for assistance and nobody answered my call light. CNA/Scheduler C stated, she finished cleaning R1 up and transferred her to the recliner. CNA/Scheduler C asked RN E to follow up regarding R1's pain. On 7/24/24 the Administrator spoke with CNA/Scheduler C (Certified Nursing Assistant) regarding an allegation made by R1. The Nursing Home Administrator (NHA) asked CNA/Scheduler C to explain what occurred on 7/7/24 with R1. CNA/Scheduler C summarized she went to assist R1 due to a call light being on. She had stool stuck in her butt crack, so it was hard to get off. It wasn't soft stool but wasn't hard. It was sticky. As I was wiping her, I could see her body wince and she started to cry. She said it was very painful. At that point, I pulled her call light in the bathroom to see if I could have the nurse come in to assist since she was in a lot of pain. I tried to just pat her back and forth with a wash cloth instead of rubbing. It took about 10-15 minutes to get her all cleaned up. I told her, I'm sorry and that I was doing my best to not hurt her, but also had to get the stool off her. After I was completed, I applied a barrier cream to her and assisted with clean clothes. I went straight to the nurse on duty RN E (Registered Nurse) and asked her if she had anything more she could give or do for R1's butt pain as she was crying because of the pain. Administrator asked if R1 had said anything to her to stop. CNA C said she did not verbally say stop. She just said it was painful and I told her I was sorry. It is important to note, during this incident of incontinence and pericare, CNA/Scheduler C indicates the following: As I was wiping her, I could see her body wince and she started to cry and she was crying because of the pain. At no point during this interaction did CNA/Scheduler C stop cares and let R1 take a break, nor did CNA/Scheduler C physically go notify the RN E. RN E (Registered Nurse) statement indicates as follows: CNA C approached me on 7/7/24 and asked if R1 is always in a lot of pain during toileting/pericare. CNA C told me that R1 was crying and verbalized she was in a lot of pain. CNA C asked if I could give her something for her butt pain specifically. I explained to her that I did not have anything for butt pain besides the calmoseptine cream. I worked a 16-hour shift and interacted with R1 off and on that day and she did not express being in distress or any pain to me. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 2:50 PM, Surveyor spoke with RN E (Registered Nurse). RN E works PRN (as needed) at the facility. Surveyor asked RN E to described what occurred during her shift on 7/7/24. RN E stated on 7/7/24 she worked from 6:00 AM-10:00 PM. RN E stated CNA/Scheduler C reported to her that she had just assisted R1 with incontinence care and it was quite painful for her. RN E stated, CNA/Scheduler C wanted her to check in with R1 after that. RN E stated when she went in the room R1 was resting in her chair. RN E stated, she did not want to disturb R1 and did not wake her up. RN E stated, during her 16-hour shift R1 did not mention the allegation. RN E stated the only order she has for R1's bottom was Calmoseptine. Collateral Statements from 7/7/24 Self Reportable: LPN D (Licensed Practical Nurse) - R1 stated to LPN D that she needed help in the bathroom and CNA/Scheduler C came in to wash her up. Resident stated, it hurt so bad and said she yelled out because it was so painful it got worse. She (R1) doesn't want her bathing her or washing her up anymore. She did it hard and it hurt. Nurse wrote up a concern form to Administrator. On 7/30/24 at 2:30 PM, Surveyor spoke with LPN D (Licensed Practical Nurse). Surveyor asked LPN D to described what occurred during her shift on 7/7/24. LPN D stated, R1 reported to her that CNA/Scheduler C was Very rough and Rough washing up my bottom and Look at her (CNA/Scheduler C), look at me she is much bigger than me and She was right there washing and didn't stop. LPN D stated she reported this to NHA A (Nursing Home Administrator). On 7/30/24 at 9:10 AM, Surveyor spoke with R1. R1 stated she has a concern with CNA/Scheduler C, R1 stated, CNA/Scheduler C treated me very roughly, more than roughly, cruelly. R1 added, I call it a brutal beating. Surveyor asked R1 did CNA/Scheduler C say anything to you. R1 stated, she didn't answer just kept on going. On 7/20/24 at 3:20 PM, Surveyors spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, what did R1 report regarding the 7/7/24 allegation. NHA A stated, R1 reported, She (CNA/Scheduler C) wiped me really hard, and it hurt. and was really painful. NHA A stated, R1 shared she has hemorrhoids and has some pain to her private area after having 6 babies. NHA stated, R1 stated she asked CNA/Scheduler C to stop but she kept on doing it and didn't say anything. NHA A stated, CNA/Scheduler C stated R1 did not tell her to stop; however, she observed and stated that R1 was crying and in visible pain. Surveyor asked NHA A, did you educate CNA/Scheduler C and other staff regarding pain and stopping cares when a resident is in pain. NHA A stated that she, DON B (Director of Nursing) and HR (Human Resources) provided education to CNA/Scheduler C over the phone; however, there is no documentation that CNA/Scheduler C was educated regarding pain. NHA A stated that other staff were not educated regarding pain. Surveyor asked NHA A, should you have educated CNA/Scheduler C and all other staff regarding pain following this allegation. NHA A stated, Yes.