

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/06/2025
NAME OF PROVIDER OR SUPPLIER  Edenbrook of Fond Du Lac		STREET ADDRESS, CITY, STATE, ZIP CODE 265 S National Ave Fond Du Lac, WI 54935	

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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342</b></p> <p>Based on staff and resident interview and record review, the facility did not provide appropriate catheter care and services for 1 resident (R) (R1) of 3 sampled residents.</p> <p>R1 had a history of kidney stones, took anticoagulant medication, and had a Foley catheter. R1 had an order to flush the catheter with acetic acid. On 4/23/25, R1's catheter was flushed with vinegar. The facility did not update R1's physician timely when R1 experienced gross hematuria (a large amount of blood in the urine).</p> <p>Findings include:</p> <p>The facility's Foley Catheter Management policy, revised 1/28/25, indicates proper care will be provided for the management of a Foley catheter to drain urine from the bladder.</p> <p>The facility's Change in Condition policy, revised 11/13/24, indicates the policy's purpose is to ensure prompt notification of the resident, the attending physician, and durable power of attorney/responsible party of changes in the resident's physical, psychosocial, and/or mental condition and/or status. The physician will be notified when there has been a change that is a marked difference in usual signs/symptoms. Specific information that requires prompt notification includes but is not limited to a medication error and a need to alter the resident's medical treatment significantly.</p> <p>On 5/6/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including neuromuscular dysfunction of bladder, chronic heart failure, and atrial fibrillation. R1's Minimum Data Set (MDS) assessment, dated 2/3/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was not cognitively impaired. R1 was responsible for R1's healthcare decisions. R1's medical record indicated R1 was hospitalized on [DATE] and readmitted to the facility on [DATE].</p> <p>R1's medical record included physician orders (which were in place prior to R1's hospitalization on [DATE]) for bladder irrigation via R1's urinary catheter. R1's physician orders indicated nurses should use 60 milliliters (ml) of 0.25% acetic acid irrigation solution to irrigate R1's bladder by flushing R1's catheter with the solution, clamping the catheter for 30 minutes, and then releasing the clamp to allow the solution to flow into the drainage bag.</p> <p>(continued on next page)</p>

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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/25 at 10:01 AM, Surveyor interviewed R1 who indicated a nurse used vinegar to flush R1's bladder. R1 stated, It burned like a fire down there. R1 indicated R1 told the nurse R1 couldn't stand it but the vinegar was already in. R1 indicated the nurse clamped R1's catheter and left the vinegar in R1's bladder for 30 minutes. R1 stated, It burned the whole time, just terrible. I don't wish that on anybody.</p> <p>R1's medical record contained the following documentation:</p> <p>A note, dated 4/23/25 at 9:40 PM, indicated R1 did not want acetic acid flushes due to a burning sensation when administered. R1 wanted to discontinue the acetic acid flush and go back to normal saline flushes. R1's physician was updated.</p> <p>R1's medical record contained a fax, dated 4/23/25, that indicated R1 refused an acetic acid flush due to a burning sensation and asked if the solution should be diluted. The fax indicated NP-D responded on 4/24/25 with an order to not dilute but decrease the frequency to once daily.</p> <p>A note, dated 4/24/25 at 10:24 AM, indicated R1's Nurse Practitioner (NP) changed the frequency of acetic acid flushes from twice daily to once daily.</p> <p>A note, dated 4/26/25 at 5:18 AM, indicated R1 did not want an acetic acid flush because it burned. R1 requested a normal saline flush instead. Normal saline was used to flush R1's bladder per R1's request.</p> <p>A note, dated 4/27/25 at 2:25 PM, indicated R1 continued to have gross hematuria. R1's NP was faxed and the facility was awaiting a response.</p> <p>R1's medical record contained a fax, dated 4/27/25, that indicated R1 continued to have gross hematuria for four days. R1's vital signs were stable. R1 did not have a fever and denied pain or discomfort. R1 was on Eliquis (used to prevent blood clots) and had a history of kidney stones. The fax indicated NP-D responded on 4/28/25 for staff to update urology.</p> <p>A note, dated 4/28/25 at 1:19 PM, indicated R1's family expressed concern regarding R1's gross hematuria for the past five days. The nurse noted red blood in R1's catheter drainage bag. R1's NP requested urology be updated and a message was left for R1's urologist.</p> <p>A note, dated 4/28/25 at 3:14 PM, indicated R1's urologist called the facility and recommended R1 be transferred to the emergency room (ER) for evaluation.</p> <p>A note, dated 4/28/25 at 3:38 PM, indicated R1's vital signs were within normal limits. There was blood in R1's urine and R1 complained of dysuria (painful urination).</p> <p>On 5/6/25 at 10:12 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R1's bladder was flushed with vinegar instead of acetic acid on 4/23/25. DON-B indicated the incident was not reported to the facility at the time and DON-B learned of the incident from R1's family on 4/29/25. DON-B spoke with nurses who all denied flushing R1's bladder with vinegar. DON-B indicated DON-B spoke via phone with the last nurse left to interview, Licensed Practical Nurse (LPN)-C, who worked the night shift. LPN-C admitted to flushing R1's bladder with vinegar on 4/23/25. DON-B disciplined LPN-C for not reporting the medication error and R1's physician should have been updated.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/25 at 10:30 AM, Surveyor interviewed NP-D who indicated NP-D heard a rumor that vinegar was used to flush R1's bladder but thought, at the time, it was a rumor and not valid. NP-D indicated DON-B updated NP-D after R1 was hospitalized that vinegar was used for a bladder flush. When asked what happens when vinegar is instilled in the bladder, NP-D indicated it could be corrosive. NP-D indicated NP-D, R1's physician, and/or R1's urologist should have been notified within 24 hours regarding R1's gross hematuria. NP-D indicated if NP-D had been notified, NP-D would have instructed staff to update R1's urologist.</p> <p>Surveyor reviewed the facility's investigation which indicated on 4/29/25, an email was received by R1's Family Member ((FM)-E) who indicated FM-E and the hospital were told R1 received vinegar flushes daily instead of acetic acid flushes. DON-B viewed notes in the hospital's medical record system which stated the facility's NP relayed the information to the hospital nurse. When DON-B asked if NP-D had reported the information to the hospital and was notified that staff completed vinegar flushes, NP-D stated no. DON-B spoke to floor nurses who stated acetic acid flushes were completed and notified the hospital that R1 had been receiving acetic acid flushes. Upon further conversation with FM-E, DON-B was told a staff had flushed R1's bladder with vinegar one night the week prior. DON-B interviewed Licensed Practical Nurse (LPN)-C who fit the description that was provided. LPN-C indicated LPN-C had flushed R1's bladder with vinegar once but did not clamp the catheter per the order and let the solution run back out into the bag because R1 stated something was not right. LPN-C indicated there were no further complaints from R1. A disciplinary action was discussed because the incident was considered an unreported medication error and LPN-C did not notify R1's physician or family. DON-B updated NP-D on the medication error. NP-D noted the update and stated the vinegar flush would do no harm. There were no new orders at that time. Staff education was in progress regarding following catheter flush orders as written. DON-B updated FM-E on the investigation.</p> <p>The investigation included a Medication Error Report (error date of 4/23/25) that indicated the wrong solution was instilled via R1's catheter. The investigation indicated LPN-C was coached on the medication error/reporting of a medication error and that all nurses were being educated on ensuring the correct solution is administered via catheter and at no time should nurses deviate or substitute the order unless ordered by the provider (dated 4/29/25).</p> <p>The investigation included an Employee Corrective Action Form signed/dated on 4/29/25 for LPN-C and a Staff Education Record with a start date of 4/29/25 through 5/6/25 which stated, By signing this, I understand that when giving report on a resident I am caring for, I will report objective information. My report will be accurate based on my direct observations and assessments. At no time will I report 'hearsay' information . (then handwritten at bottom) To note - catheter flushes are to be done with the solution ordered by the provider. At no time will we be substituting without approval from the provider. The handwritten section was signed by DON-B.</p> <p>On 5/6/25, Surveyor reviewed emails to/from FM-E and DON-B that indicated:</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ An email from FM-E dated 4/28/25 at 10:07 PM, indicated: (R1) mentioned (R1) was told at your facility it was part vinegar .It was unlike (R1) today when (R1) told (family member) not to come visit because (R1) was in bed hoping to minimize the blood loss. (Family member) then called RN around (1:30 PM) to check on (R1's) bleeding status and get an update. It was concerning to (family member) when (family member) was informed by the RN that (RN) didn't know how (R1) was or the status of the bleeding today, but it was noted by night shift (R1) was still bleeding last night. (Family member) requested that a reason for the bleeding be determined and mentioned wondering if repositioning the (catheter) would reduce the bleeding. (Family member) also said (family member) (would) feel best if urology was advised of the 5 days of bleeding. This was all around 1:30 PM. At (3:00 PM), (family member) was advised by your facility that (R1's urologist) wanted (R1) at the ER.</p> <p>~ DON-B's response on 4/29/25 at 8:41 AM indicated: I am unsure where the vinegar discussion came from. I did hear the same rumor, so I have interviewed all the staff .and came to the conclusion that at no time was the flush completed with vinegar. I talked to (R1) a few days back to reassure (R1) .I will talk with the nurse that was here yesterday on the day shift. I agree, (the nurse) should have known the status of (R1's) urine well before 1:30 PM. If that is indeed the case, I will make some corrections with that nurse. I hope (R1) is doing ok .According to the notes I'm seeing at the hospital, it sounds like those stones are the culprit.</p> <p>On 5/6/25, Surveyor reviewed R1's hospital records which indicated R1 was hospitalized from 4/28/25 to 5/1/25 with bladder calculi (stones) and gross hematuria. Hospital records indicated a computed tomography (CT) scan conducted 4/28/25 revealed stones in R1's bladder and significantly decreased stone burden on the left kidney (compared to a previous study).</p> <p>On 5/6/25 at 11:48 AM, Surveyor interviewed DON-B who indicated DON-B had overheard the buzz at the nurses' station about vinegar being used but at the end of the day it was hearsay. DON-B indicated it occurred approximately two days prior to R1's hospitalization . DON-B indicated DON-B spoke with R1 about the flushes, but could not recall when the discussion occurred. DON-B indicated R1 complained that the flushes burned. DON-B reassured R1 they were the same flushes R1 had been getting the entire time. DON-B indicated R1 never used the word vinegar during the conversation.</p> <p>On 5/6/25 at 12:33 PM, Surveyor interviewed LPN-C via phone. LPN-C indicated LPN-C was unable to locate the vials of acetic acid for R1's catheter flush and thought acetic acid and vinegar were the same so LPN-C used vinegar to flush R1's catheter. LPN-C indicated once the vinegar entered R1's bladder, R1 complained of burning so LPN-C did not clamp the catheter. LPN-C indicated when LPN-C came back to work the next night shift, LPN-C was told by the PM shift nurse that R1 complained about burning with flushes. LPN-C indicated, at the time of the incident, LPN-C thought acetic acid and vinegar were the same but now knows the dilution is different. LPN-C indicated LPN-C has used acetic acid since. LPN-C indicated there was no blood in R1's urine immediately after the vinegar flush. LPN-C indicated LPN-C observed blood in R1's collection bag a day or two after the incident. LPN-C indicated LPN-C did not document the incident and learned later that it was considered a medication error.</p> <p>On 5/6/25 at 2:09 PM, Surveyor interviewed DON-B who indicated typically blood in the urine should prompt notification to the physician right away. DON-B verified the description of gross hematuria in R1's notes (as indicated above) was likely more than just pink-tinged urine. DON-B indicated there were several conversations regarding the blood in R1's urine between the nurses, NP-D, and DON-B, however, the conversations were not documented. DON-B verified the facility had not provided education to staff about reporting blood in urine timely to the physician.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/25 at 9:43 AM, Surveyor interviewed Urologist (UR)-F via phone. UR-F indicated acetic acid is not an irrigating solution UR-F typically uses. UR-F indicated R1's primary physician ordered acetic acid flushes when normal saline flushes no longer seemed to help R1. UR-F indicated the fine print on the pre-mixed acetic acid solution indicates the pre-mixed solution can cause bleeding or discomfort. UR-F indicated straight vinegar would be an irritant. UR-F stated UR-F had treated R1 since 2019 and indicated R1 had a history of hydronephrosis (the swelling of a kidney due to a build-up of urine) and required catheter replacement several times. R1 started with bleeding during the summer of 2024 and had a large kidney stone in R1's left kidney as well as bladder stones. UR-F advised surgical intervention but then R1 became sick and medically decompensated with other issues. UR-F indicated at some point, R1's primary physician changed from normal saline flushes to acetic acid flushes. UR-F indicated typically if a patient experiences bleeding with a catheter, the provider should be updated within a day. UR-F indicated R1's case was challenging because R1 had a history of bladder stones, received anticoagulation, and was recommended for surgery. UR-F indicated when UR-F was consulted at the hospital on 4/28/25, R1 was not passing significant clots but R1's output was low. UR-F indicated in R1's case, UR-F would like to have been notified as soon as the bleeding occurred. UR-F indicated after five days of bleeding, R1's blood counts were still fine but R1 had a big pile of stones in R1's bladder that needed to be cleared out.</p>		