

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 06/11/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure adequate supervision was provided for 1 resident (R) (R28) of 2 residents reviewed for elopement. R28's care plan indicated R28 was at risk for wandering/elopement after an episode of confusion while outside on 10/7/24. A WanderGuard (a security device that triggers an alarm if the wearer exits the facility) was placed on R28's left ankle. On 5/20/25 at 3:36 AM, the local police department notified the facility that R28 was found two and a half blocks from the facility. Staff were unaware R28 had left the facility. An assessment indicated R28 had no injuries. An investigation determined R28 exited the facility through the front door which had an alarm that sounded, however, staff did not follow the facility's procedure to conduct a search of the perimeter outside or complete a head count when the alarm sounded. The facility's failure to provide adequate supervision for a resident assessed to be at risk for elopement and staffs' failure to follow the facility's elopement procedure created a finding of immediate jeopardy that began on 5/20/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 6/10/25 at 1:45 PM. The immediate jeopardy was removed on 5/20/25 and corrected on 5/26/25. The deficiency is being cited as past non-compliance. Findings include: The facility's Elopement/Unsafe Wandering policy, with a review date of 6/2/22, indicates: Door Alarm: Procedure on How to Respond When an Armed Door Alarms: 1. All staff must respond immediately to any door alarm. 2. Staff must identify which door was triggered. 3. Notify the Administrator (NHA) and Director of Nursing (DON) that an exit door alarm was triggered. 3. Staff responding to a door alarm must open the alarming door, check the outside of the building and the immediate surrounding area to make sure no resident exited the building through that door. 4. Unit nurse must immediately conduct a head count of all residents on the unit to make sure everyone is accounted for. Report the final count to the DON/designee. 5. If a resident is identified as missing (a resident who has left the facility without signing themselves out of the facility or has wandered away from the facility), initiate the following steps: a. Notify the Administrator and DON immediately b. Notify the charge nurse c. Call a Code Yellow (missing resident). On 6/9/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, diabetes, insomnia, anxiety, and depression. R28's Minimum Data Set (MDS) assessment, dated 4/3/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R28 had moderately impaired cognition. R28 had a court-appointed Guardian. R28's care plan, revised on 4/7/25, indicated R28 was at risk for elopement/wandering/leaving the facility without notice. R28 had a WanderGuard because it was unsafe for R28 to go outside and ambulate on R28's own due to a large hill that put R28 at risk (for falls). R28's care plan also indicated R28 was at high risk for falls due to Parkinson's disease with a history of a fall and fracture while outside the facility in October 2024. A skilled nursing note, dated 12/1/24, indicated R28 attempted to exit the facility but was redirected by staff. On 6/9/25, Surveyor reviewed the facility's investigation which indicated on 5/20/25 at approximately 3:20 AM, staff were alerted to the front door alarm. Certified Nursing Assistant (CNA)-E had difficulty disarming the alarm box and requested assistance from Med Tech (MT)-F who silenced the alarm using a system-wide override code. Staff did not complete a check of the area outside the facility, did not conduct a head count of residents, and did not notify Registered Nurse (RN)-G of the alarm. Approximately ten to fifteen minutes later, the facility was notified by the local police department that they had R28 in their custody approximately two blocks from the facility. R28 was last seen by staff walking up and down the unit at approximately 2:30 AM. The police report indicated the police department received a call at 3:26 AM of an elderly male walking in the street wearing a dark coat and a tan hat. The police called the facility at 3:36 AM and returned R28 to the facility at 3:44 AM. R28's statement indicated R28 was not sure if R28 was going to be able to get out but R28 wanted to test the fortress and see how far R28 could get. R28 indicated R28 was gone for approximately forty five minutes and had left R28's walker behind in R28's room on purpose. CNA-E's statement, dated 5/20/25, indicated CNA-E was in the bathroom when CNA-E heard the front door alarm sounding. CNA-E was unable to disarm the system by using the door alarm code and asked MT-F for assistance. CNA-E did not notify RN-G that the door alarm sounded or conduct a check outside the facility to see if any residents had exited through the front door. CNA-E then returned to CNA-E's duties. MT-F's statement, dated 5/20/25, indicated MT-F disarmed the door alarm by using the WanderGuard override code and returned to MT-F's assigned unit. MT-F stated MT-F did not think to ask CNA-F if CNA-F checked outside for residents. MT-F stated MT-F was not aware that R28</p>		