STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525299	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Oshkosh	1850 Bowen St Oshkosh, WI 54901

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure an allegation of neglect was thoroughly investigated for 1 resident (R) (R2) of 15 sampled residents. R2 alleged that Certified Nursing Assistant (CNA)-H left R2 naked and without a gown on the 6/18/25 night shift. The facility did not thoroughly investigate the allegation of neglect.Findings include: The facility's Policy & Procedure Vulnerable Adult Abuse and Neglect Prevention, revised 3/25/25, indicates: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, neglect, mistreatment, or exploitation. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thoroughly investigate allegations .residents and staff will be protected from abuse, neglect, and harm while they are residing at the facility. There is zero tolerance for abuse or harm of any type .The facility will strive to educate all participants in techniques to protect all parties .Willful .means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .11. Neglect: (a) The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (b) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, healthcare, or supervision which is: i. Reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety .and ii. Which is not the result of an accident or therapeutic conduct. (c) The absence or likelihood of absence of care services, including but not limited to food, clothing, shelter, healthcare, or supervision necessary to maintain the physical and mental health which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety or comfort .Resident Protection Program Policy & Procedure: .4. Investigation: a. Upon receiving a complaint of alleged maltreatment, the Administrator must be notified immediately and they, the Director of Nursing (DON), or assigned designee will coordinate an investigation which will include completion of witness statements. b. All parties involved including two of the following - staff, residents, or visitors who were potentially involved or observed the alleged incident are to be interviewed by the DON, Director of Social Services, or their designee .j. The investigation and written findings are completed and reviewed with the Administrator, DON, and Director of Social Services .h. Education will be provided as needed to all parties involved .Each alleged report will be individually investigated .The appropriate person .or designee will conduct interviews with the appropriate staff, volunteers, visitors, etc. Within 5 business days, an investigation report will be completed and turned into the Department of Health which includes .iii. Details of the facility's investigation including a summary of information obtained from interviews of residents, staff, and witnesses .vii. Any action that has been taken to prevent recurrence of the incident . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including aftercare following joint replacement surgery, diabetes, asthma, and obesity. R2's Minimum Data Set (MDS) assessment, dated 6/23/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 was not cognitively impaired. R2 made R2's own healthcare decisions. A care plan, dated 6/18/25, indicated R2 required the assistance of one staff for dressing. On 7/1/25, Surveyor reviewed a facility-reported incident (FRI) that contained a grievance from R2, dated 6/19/25, that indicated on the 6/18/25-6/19/25 night (NOC) shift, staff did not answer R2's call light and R2 used a phone to call for assistance. The investigation indicated CNA-H removed a bed pan from underneath R2 at 1:00 AM and the bed pan spilled. R2's gown was wet and CNA-H did not assist with R2's wet gown until R2 asked. R2 indicated CNA-H removed R2's wet gown, left R2 naked, left the room, and did not return. R2 called at 4:00 AM and a Registered Nurse (RN) assisted R2 with donning a clean gown. R2 indicated CNA-H was rude when R2 requested an RN and told R2 the RN was busy. R2 indicated CNA-H always stood at the door which made R2 feel as if CNA-H did not want to take care of R2 and always rushed to get out which hurt R2's feelings. Surveyor noted the FRI did not contain an interview or statement from the RN who assisted R2 with the gown. In addition, the education the facility provided to staff did not include customer service or dignity which was part of R2's grievance and did not include all staff who worked the 6/18/25-6/19/25 night shift. The facility provided a nursing staff list which contained 38 CNAs. Surveyor noted the facility's education sheets were completed with only 34% of the CNAs who worked on the shift when the incident occurred. The FRI also did not include an investigation for why R2 used a phone to call for assistance instead of the call light. The investigation did not indicate how long R2 was left naked or if R2 was still naked when the RN assisted R2 with a clean gown. On 7/1/25 at 8:49 AM, Surveyor interviewed R2 who indicated R2 was left in urine for hours. R2 stated R2 did not want to use the call light because staff do not answer call lights timely and instead used R2's phone to call for assistance. R2 indicated CNA-H was terminated because CNA-H was rude and left R2 naked without a gown for a long time. R2 indicated the gown was soiled after R2 used the bedpan. R2 indicated an unknown nurse assisted R2 with a clean gown. R2 indicated other unknown staff were also rude. On 7/1/25 at 9:17 AM, Surveyor interviewed R13 who indicated some staff have loud and rude voices which R13 does not like. R13 indicated an unknown nurse administered medications in one spoonful and R13 felt the nurse rushed to administer the medication. R13 also indicated a male staff entered R13's room during the night in the past two weeks and turned off the light above R13's bed. R13 indicated R13 used the light as a night light and was afraid of the dark. R13 indicated Director of Nursing (DON)-B informed R13 that the staff was let go. When Surveyor asked if the staff was aware that R13 liked the light on at night, R13 stated yes. On 7/1/25 at 9:43 AM and 1:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the concerns regarding CNA-H were a form of neglect and CNA-H no longer worked at the facility. NHA-A indicated the primary issue was that CNA-H was rude and made residents feel rushed, however, CNA-H denied the allegations. NHA-A indicated R2 being left without a gown was a he said/she said situation and NHA-A did not know which nurse was on duty that night. NHA-A also indicated other residents complained of customer service issues with CNA-H.