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	07/29/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure 2 residents (R) (R2 and R9) of 3 sampled residents received the appropriate care and services to prevent urinary tract infections (UTIs). The facility did not initiate or transcribe an admission order to change R2's Foley catheter monthly and as needed.The facility did not initiate or transcribe a urology clinic order to change R9's Foley catheter monthly and as needed. In addition, R9 was not placed on enhanced barrier precautions (EBP) despite having an indwelling medical device.Findings include:The facility's Physician Orders policy, revised 11/13/24, indicates orders must be recorded in the medical record and transcribed to the Medication Administration Record (MAR) or Treatment Administration Record (TAR). The facility's Foley Catheter Management policy, revised 1/28/25, indicates there will be a medical necessity/justification for the use of a urinary catheter which will be identified by the physician order. The policy also indicates indwelling Foley catheters will not be changed at routine or fixed intervals. The facility's Enhanced Barrier Precautions (EBP) policy, dated 3/26/25, indicates the facility will implement EBP during high-contact resident care activities when caring for residents who have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with an indwelling medical device. EBP refers to an infection control intervention that employs targeted gown and glove use during high-contact resident care activities. A posting with clear signage of EBP should be placed on the door/wall outside the resident's room and the facility will ensure personal protective equipment (PPE) and alcohol-based hand rub is readily accessible to staff. 1. On 7/29/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, traumatic ischemia/rhabdomyolysis, and history of falls. R2 had an Activated Power of Attorney for Healthcare (POAHC) who assisted with medical decisions. R2's Minimum Data Set (MDS) assessment, completed on 6/19/25, indicated R2's cognition was severely impaired. Hospital discharge instructions, dated [DATE], indicated R2 had a UTI upon admission and a chronic Foley catheter. Physician orders upon discharge from the hospital were to change the Foley catheter monthly and irrigate with 60 milliliters (ml) of normal saline as needed. Surveyor noted the order was not transcribed in R2's medical record and was not on R2's MAR or TAR.On 7/29/25 at 1:01 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the hospital discharge order should have been transcribed in R2's TAR; however, the facility's policy indicates not to complete Foley catheter changes routinely or at fixed intervals to prevent the possibility of causing infection. DON-B indicated R2's physician should have been notified of the order and should have provided an order to change the Foley catheter as needed with indications, including but not limited to if the catheter is plugged and if R2 has decreased urine output or urinary changes. DON-B indicated R2's physician did not provide alternative orders and verified the hospital discharge order should have been transcribed and implemented. 2. On 7/29/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, hemiplegia, hemiparesis, UTI, and diabetes. R9 made R9's own medical decisions. R9's MDS assessment, completed on 7/3/25, indicated R9's cognition was moderately impaired. R9's medical record contained an order from the urology clinic, dated 7/22/25, for monthly and as needed Foley catheter changes. The order was not transcribed on R9's MAR or TAR.On 7/29/25 at approximately 12:30 PM, Surveyor interviewed R9 who indicated R9 had an order from the urology clinic on 7/22/25 to change R9's Foley catheter but it had not been changed. Surveyor did not observe an EBP sign outside R9's room and did not observe PPE near R9's room. On 7/29/25 at 12:36 PM, Surveyor interviewed Registered Nurse (RN)-D who verified R9 had a Foley catheter but indicated R9 did not need to be on EBP. On 7/29/25 at 12:38 PM, Surveyor observed the outside of R9's room with DON-B who indicated R9 should be on EBP due to the Foley catheter. Surveyor observed DON-B post an EBP sign outside R9's door.On 7/29/25 at 1:01 PM, Surveyor interviewed DON-B who verified R9 had an order from the urology clinic on 7/22/25 for monthly and as needed Foley catheter changes. DON-B indicated the order should have been transcribed on R9's TAR which DON-B completed during the interview. DON-B indicated nursing staff would implement the urology clinic order on the 7/29/25 PM shift and confirmed the order should have been transcribed when received on 7/22/25.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R2) of 1 sampled resident received timely laboratory services. The facility did not complete physician orders for R2 to prevent potential cancellation or delay of a medical procedure. Findings include: The facility's Physician Orders policy, revised 11/13/24, indicates the purpose of the policy is to ensure physician orders are transcribed and implemented in accordance with professional standards. The policy also indicates orders must be recorded in the medical record and transcribed to the Medication Administration Record (MAR) or Treatment Administration Record (TAR). On 7/29/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, traumatic ischemia/rhabdomyolysis, history of falls, and sick sinus syndrome. R2 had an activated Power of Attorney for Healthcare (POAHC) who assisted with medical decisions. R2's Minimum Data Set (MDS) assessment, completed on 6/19/25, indicated R2's cognition was severely impaired. R2's medical record contained orders from the urology clinic on 7/7/25 with surgical instructions and indicated the failure to comply may result in cancellation of R2's procedure. The orders included a pre-op history and physical (H&P) to be completed no more than 30 days prior to the procedure scheduled for 7/25/25 and a urine culture on 7/11/25. On 7/29/25 at 9:09 AM, Surveyor interviewed Assisted Living Nurse (ALN)-C who indicated R2's medical procedure was delayed because the physician's orders were not completed timely. On 7/29/25 at 1:01 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the facility received orders from the urology clinic on 7/7/25 to provide a pre-op H&P and complete a urine culture on 7/11/25. DON-B indicated the pre-op H&P was completed by the facility's provider on 7/8/25, however, the facility did not send the H&P to the urology clinic. DON-B also indicated nursing staff could not obtain a urine sample as ordered on 7/11/25 because R2 left the facility at 9:45 AM. DON-B indicated the facility should have notified R2's receiving facility that the order was not completed and needed to be completed to ensure continuity of care and prevent the delay of R2's surgical procedure.