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	05/05/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 4 residents (R) (R1, R18, R53, and R41) of 4 sampled residents received the necessary care and services to prevent pressuries injuries from developing or worsening and/or promote healing.R1 was admitted to the facility with stage 3 and 4 pressure injuries. During wound care, Registered Nurse (RN)-H applied ointment to the wound bed of R1's stage 4 left buttock pressure injury with a soiled glove.R18's specialty air mattress was not turned on during an observation on 5/3/26. In addition, R18 did not have an order for the mattress and the setting wasn't indicated in R18's medical record. R53 and R41's specialty air mattresses were not set correctly.Finding include: The facility's Pressure Injury Prevention and Wound Care Management policy and procedure, revised 8/25/25, indicates: .A resident who has a pressure injury will receive care and services to promote healing and prevent additional ulcers .Air mattress settings will be set per manufacturer's guidelines and communicated to staff via the care plan and Kardex (an abbreviated care plan used by nursing staff) .The goals of wound treatment are to: .Protect the ulcer from contamination. 1. From 5/3/26 to 5/5/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including spina bifida, paraplegia, and neuromuscular dysfunction of bladder. R1's Minimum Data Set (MDS) assessment, dated 2/27/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1's cognition was intact. R1's medical record indicated R1 had a stage 4 pressure injury on the left buttock and a stage 3 pressure injury on the right buttock for which R1 was evaluated by wound physicians monthly. R1's wounds were chronic. R1 routinely refused to offload pressure. R1's medical record contained a wound care order to apply wound ointment two times daily and as needed to buttocks (dated 4/21/26). On 5/4/26 at 11:27 AM, Surveyor observed Registered Nurse (RN)-H don a gown and enter R1's room with wound ointment in a cup and a tongue depressor. RN-H completed hand hygiene, applied gloves, and assisted R1 onto the right side. When RN-H pulled the privacy curtain, R1 stated R1 wanted the curtain open. RN-H opened the curtain. RN-H applied wound ointment to R1's right buttock pressure injury and around the left buttock pressure injury with the tongue depressor. RN-H dipped RN-H's gloved fingers in the cup of ointment and applied the ointment to the wound bed of R1's left buttock pressure injury. RN-H then removed the gown and gloves and completed hand hygiene. RN-H repositioned R1 onto R1's back and exited the room. On 5/4/26 at 11:36 AM, Surveyor interviewed the facility's wound care nurse (RN-I) who verified the treatment for R1's pressure injury was to apply ointment. RN-I indicated the wound should have been (continued on next page)

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
	525299	A. Building B. Wing	05/05/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleansed with soap and water prior to applying ointment. RN-I verified there was not an order to cleanse the wound prior to applying ointment; however, RN-I felt RN-H should have followed standard practice to cleanse the wound prior to applying ointment. RN-I indicated RN-H should have removed gloves, cleansed hands, and donned clean gloves after repositioning R1 and touching the privacy curtain. RN-I indicated RN-H should have used the tongue depressor to apply ointment to the inside of the pressure injuries, removed gloves, and cleansed hands and should have donned clean gloves and used another tongue depressor to apply ointment to the outside of the pressure injuries. On 5/4/26 at 12:06 PM, Surveyor interviewed RN-H who confirmed RN-H should have applied ointment to the wound bed with a tongue depressor prior to applying ointment to the outside of the wound. 2. Between 5/3/26 and 5/5/26, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including unspecified protein calorie malnutrition and encounter for palliative care. R18 received Hospice services. R18's MDS assessment, dated 4/15/26, had a BIMS score of 6 out of 15 which indicated R18 had severely impaired cognition. A Braden Scale assessment, dated 4/9/26, indicated R18 was at risk for skin breakdown. A skin care plan, initiated 4/9/26, contained an intervention for a specialty mattress to relieve pressure (initiated 4/10/26). R18 had an ATLAS 5 Minds mobility air mattress. The manufacturer's instructions indicate: The ATLAS mattress is a self-adjusting air mattress and can be used without a pump, however, this manual describes its use with a pump. Step 1: Turn on the power. Weight/pressure set up: Users can adjust air flow to the mattress to a desired firmness according to the user's weight or the suggestion from a healthcare professional. On 5/3/26 at 10:02 AM, Surveyor interviewed R18 and noted R18's air mattress was not on. R18 wasn't sure why the mattress was not on and indicated staff do not do anything with the air mattress. On 5/4/26 at 2:10 PM, Surveyor observed R18 in bed and noted R18's air mattress was turned on. R18 stated Hospice Nurse (HN)-L was just in the room, noticed the mattress was not on, and turned the mattress on. The mattress was set at 180. R18 indicated the mattress felt fuller in R18's back area and stated R18 did not have any wounds. On 5/4/26 at 2:13 PM, Surveyor exited R18's room and observed Assistant Director of Nursing (ADON)-E talking to HN-L. HN-L verified HN-L noted R18's mattress was not on and turned it on. Surveyor informed ADON-E that R18's mattress was not on during an observation on 5/3/26. Surveyor also indicated R18's orders and care plan did not contain a mattress setting. ADON-E confirmed there should be orders. HN-L stated HN-L would provide orders. ADON-E confirmed staff should check a resident's air mattresses to ensure it is functioning as indicated by an order in the resident's Treatment Administration Record (TAR). HN-L indicated Hospice provided R18 with the mattress shortly after R18 was admitted to the facility. ADON-E stated R18's mattress does not need air to provide support and can be a regular mattress or an air mattress. On 5/4/26 at 10:46 AM, Surveyor interviewed Director of Nursing (DON)-B who stated sometimes Hospice staff provide air mattresses without telling the facility. DON-B stated if Hospice staff set the mattress at 180, that is the setting staff follow. DON-B indicated orders were just entered for R18 and R18's care plan was updated. (continued on next page)

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	05/05/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Between 5/3/26 and 5/526, Surveyor reviewed R53's medical record. R53 was admitted to the facility on [DATE] and had diagnoses including fractured tibia, risk for delayed healing related to anemia, at risk for pressure ulcer related to Foley catheter, and blister left shoulder. R53's MDS assessment, dated 3/20/26, had a BIMS score of 15 out of 15 which indicated R53 had intact cognition. R53 made R53's own healthcare decisions. A care plan, dated 12/19/24, indicated R53 was at risk for skin alteration. The care plan contained an intervention for a specialty air mattress. R53's medical record contained an order, dated 10/30/25, to check the air mattress is functioning properly and set to 110-180 every shift A Braden Scale assessment, dated 4/14/26, indicated R53 was at risk for skin breakdown. R53 had a Proactive Air Mattress Selectis Serenity 2000/3000. The manufacturer's recommendations indicate to set the pressure dial or digital input to the user's exact body weight. On 5/3/26 at 10:43 AM and 5/4/26 at 2:02 PM, Surveyor noted R53's air mattress was set at 320. On 5/4/26 at 2:48 PM, Surveyor and DON-B observed R53's air mattress which was set at 320. DON-B verified the setting was incorrect and set the air mattress to 150. 4. Between 5/3/26 and 5/526, Surveyor reviewed R41's medical record. R41 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, diabetes, risk for delayed healing, below the knee amputee, and risk for pressure ulcer related to Foley catheter. A care plan, dated 10/16/25, indicated R41 was at risk for skin alteration. The care plan contained an intervention for a specialty air mattress. R41's medical record contained an order, dated 2/5/26, for a Drive air mattress set to weight 180-250. (Of note: The manufacturer's recommendations indicate to select the setting based on the patient's weight, comfort, and tolerance.) A Braden Scale assessment, dated 5/5/26, indicated R41 was at risk for skin breakdown. On 5/4/26 at 2:44 PM, Surveyor observed R41's air mattress and noted it was set at 620. On 5/4/26 at 2:58 PM, Surveyor and DON-B observed R41's air mattress which was set at 620. DON-B verified the setting was incorrect and set the air mattress to 218.

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	05/05/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Pre-admission Screening and Resident Review (PASRR) Level I Screen was accurately completed and a Level II Screen was completed for 1 resident (R) (R8) of 7 sampled residents.R8 was admitted to the facility with diagnoses including schizoaffective disorder and anxiety disorder and was prescribed antianxiety medication. The facility did not correctly identify R8's mental illness diagnoses or medication on a PASRR Level I Screen and did not submit for a Level II Screen.Findings include:From 5/3/26 to 5/5/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including schizoaffective disorder and anxiety disorder. R8's Minimum Data Set (MDS) assessment, dated 4/16/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R8 had moderate cognitive impairment. R8 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions.R8's PASRR Level I Screen, dated 4/16/26, indicated R8 did not have a major mental disorder and was not prescribed major tranquillizer or antipsychotic medication. Based on the information provided on the Level I Screen, the facility did not submit for a Level II Screen. (Of note: The PASRR Level I Screen did not reflect R8's diagnoses of schizoaffective disorer or anxiety disorder.)R8 had a physician order, dated 4/17/26, for lorazepam (antianxiety medication) for use as needed for anxiousness. (Of note: R8's PASRR Level I Screen did not indicate R8 was prescribed lorazepam for anxiety.On 5/4/26 at 1:34 PM, Surveyor interviewed Social Services Aide (SSA)-D who stated an updated PASRR Level I Sreen and referral for a Level II Screen were submitted on 5/3/26 due to R8's order for lorazepam. SSA-D stated R8 admitted to Hospice services while at the facility on 4/16/26 and a PASRR Level II Screen would not have been done because R8 was not on medication for schizoaffective disorder.On 5/4/26 at 1:53 PM, Surveyor interviewed Certified Social Worker (CSW)-C who stated CSW-C would not have initiated a PASRR Level II Screen since R8 was not on medication for schizoaffective disorder at the time of admission. When Surveyor indicated R8's PASRR Level I Screen did not indicate R8 had a major mental disorder, CSW-C stated it was overlooked. CSW-C also stated since there was no medication prescribed, CSW-C would not have sumitted for a PASRR Level II Screen. CSW-C verified a PASRR Level II Screen should have been submitted when lorazepam was ordered on 4/17/26. CSW-C verified PASRR Level I and Level II Screens were submitted on 5/3/26 to accurately reflect R8's diagnoses and lorazepam order.

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	05/05/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure their bowel protocol was followed or daily weights were obtained for 2 residents (R) (R30 and R15) of 2 sampled residents.R30 went 4 days without a bowel movement. R30 was not offered medication to help promote a bowel movement on day 3 per facility protocol. R15 was not weighed daily in accordance with a physician's order.Findings include: The facility's standing orders include: ~ Milk of Magnesia (MOM) 30 milliliters (ml) by mouth as needed (PRN) on third day without bowel movement (BM) except in renal failure or with glomerula filtration rate (GFR) of less than 45 ~ Senna-docusate sodium tablet 8.6-50 milligrams (mg) 1 tablet by mouth every 12 hours as needed for constipation and/or if no bowel movement in 3 days ~ Fleet enema as needed for constipation if no results from the suppository ~ Maalox 15-30 ml every 2 hours as needed for gastrointestinal (GI) distress 1. Between 5/3/26 and 5/5/26, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including displaced intertrochanteric fracture of the left femur, irritable bowel syndrome, and pain in left knee. R30's Minimum Data Set (MDS) assessment, dated 4/23/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R30 had moderate cognitive impairment. R30 was R30's own decision maker. On 5/4/26 at 9:00 AM, Surveyor interviewed R30 who indicated R30 experienced occasional constipation since admission to the facility. R30 stated R30 had been eating Nutrigrain bars to help with bowel movements. R30 stated staff had not offered stool softeners or any bowel medications for constipation. R30 stated R30 used stool softeners and digitally removed stool from R30's rectum at home due to constipation prior to admission. R30 had the following orders: ~ MiraLax oral powder 17 grams (gm)/scoop - Give 1 scoop by mouth as needed (PRN) daily for constipation ~ Milk of Magnesia oral suspension 2400 mg/30 ml - Give 30 ml by mouth as needed daily for constipation ~ Fleet enema rectal enema 19-7 gm/197 ml - Insert 1 application rectally as needed daily for constipation ~ Bisacodyl rectal suppository 10 mg - Insert 1 suppository rectally as needed daily for constipation R30's medical record indicated the following: ~ R30 did not have a bowel movement on 4/25/26, 4/26/26, 4/27/26, or 4/28/26 (4 days). (continued on next page)

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	05/05/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ There were no documented PRN bowel medications administered for R30 since admission. ~ R30's Medication Administration Record (MAR) and progress notes contained no documented refusals of bowel medications. On 5/4/26 at 9:09 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who stated nurse managers give floor nurses a list of residents daily who need medication for constipation. If a resident refuses the medication, it is documented in their medical record. On 5/4/26 at 12:50 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-E regarding the facility's protocol for PRN bowel medications. ADON-E stated if a resident has not had a bowel movement in 72 hours, PRN bowel medication is administered. If the resident doesn't have a bowel movement in 5 days, a rectal suppository is administered. If a resident refuses, it is documented in their medical record. On 5/5/26 at 10:56 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R30 should have been offered bowel medication on day 3 when R30 went 4 days without a documented bowel movement. 2. Between 5/3/26 and 5/5/26, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including acute on chronic heart failure with preserved ejection fraction (CMD), acute hypoxic respiratory failure, and moderate pulmonary hypertension. R15's MDS assessment, dated 5/11/26, had a BIMS score of 15 out of 15 which indicated R15 had intact cognition. R15 was R15's own decision maker. R15 had an order upon admission for daily weights for 3 days (dated 4/28/26). On 4/29/26, staff obtained R15's weight in a wheelchair but did not obtain R15's weight out of the wheelchair. An accurate weight was not documented. R15's medical record indicated R15 was seen by the physician on 4/30/26 for follow-up after a recent hospitalization. R15 was hospitalized from [DATE] to 4/21/26 for a right total knee replacement. R15 was transferred to the Emergency Department (ED) on 4/23/26 with acute respiratory failure secondary to volume overload and suspected underlying interstitial lung disease (inflammation or scarring of lung tissue causing breathlessness and dry cough). R15 remained on Bumex (a diuretic medication used to treat edema (fluid retention)). The facility could not track/trend R15's weight because they had only obtained one weight since admission. On 4/30/26 and 5/1/26, R15's weight was not obtained. On 5/2/26, an order was entered in R15's medical record for daily weights. On 5/2/26, R15's weight was not obtained. On 5/4/26 at 1:33 PM, Surveyor interviewed DON-B who confirmed R15 should have been weighed on the above dates. DON-B stated if staff are unable to obtain a weight, there should be a note in the resident's medical record.

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	05/05/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R7 and R1) of 3 sampled residents received appropriate care and services to prevent urinary tract infections (UTIs).The facility did not ensure R7 and R1 received catheter care in a manner that decreased the risk for infection. R7's catheter bag and tubing were on the floor on multiple occasions. R1's uncovered catheter bag was also on the floor. Findings include: The facility's Policy & Procedure Catheter Care, revised 1/28/25, indicates: Staff will maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function, and prevent infection and other complications. 1. On 5/3/26, Surveyor reviewed R7's medical record. R7 had diagnoses including type 2 diabetes with other circulatory complications, chronic kidney disease stage 3, and urinary tract infection (UTI) (dated 3/24/26). R7's Minimum Data Set (MDS) assessment, dated 3/2/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 had intact cogntion. R7's care plan, revised 3/6/26, indicated R7 had alteration in elimination related to an indwelling catheter due to obstructive uropathy. R7 saw urology and had several failed voiding trials. The care plan contained a goal that indicated R7 would have no complications related to the indwelling catheter. The care plan contained an intervention to ensure the catheter bag and tubing were off the floor (dated 7/1/25). On 5/3/26 at 10:13 AM and 5/4/26 at 4:47 AM, Surveyor observed R7 asleep in bed and noted R7's catheter bag and tubing were on the floor next to the bed. On 5/4/26 at 5:06 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who verified CNA-F completed catheter care for R7 at 3:30 AM. During the interview, Surveyor and CNA-F observed R7's catheter bag and tubing on the floor next to R7's bed. CNA-F indicated the catheter bag and tubing should not be on the floor and should be hung from R7's bed. On 5/5/26 at 7:33 AM, Surveyor noted R7's catheter bag was hung from side of the bed and was off the floor. The catheter bag contained a red substance. On 5/5/26 at 7:36 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-E who was not aware of the red substance in R7's catheter bag and observed the bag with Surveyor. ADON-E stated ADON-E would update the Nurse Practitioner (NP) who was doing rounds about possible blood in R7's catheter bag. ADON-E stated R7's bed is older and at times it is diffiult to hang the catheter bag on the side of the bed. ADON-E verified leaving a catheter bag and tubing on the floor is not conducive to the prevention of infection. ADON-E stated ADON-E was also the facility's Infection Preventionist and woud determine other ways to create a barrier so R7's catheter bag was not in contact with the floor. On 5/5/26 at 9:43 AM, ADON-E indicated to Surveyor the NP would order a urinalysis and culture for R7 due to blood in R7's catheter bag. (continued on next page)

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	05/05/2026

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	2. From 5/3/26 to 5/5/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including spina bifida, paraplegia, UTIs, and neuromuscular dysfunction of bladder. R1's MDS assessment, dated 2/27/26, had a BIMS score of 14 out of 15 which indicated R1 had intact cognition. R1's care plan for elimination, revised 2/24/26, contained an intervention to maintain catheter and tubing off the floor. R1's medical record indicated R1 had UTIs on 1/10/26 and 4/12/26 and was treated with antibiotics. On 5/3/26 at 12:55 PM, Surveyor observed R1's uncovered catheter bag on the floor next to R1's bed. On 5/3/26 at 1:04 PM, Surveyor interviewed CNA-J who indicated R1's catheter bag should not be on the floor. CNA-J entered R1's room, removed the bag from the floor, and hung the bag on the side of R1's bed.

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	05/05/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 the accurate administration of medication for 1 resident (R) (R15) of 6 sampled residents. R15 did not receive gabapentin (an anticonvulsant medication often used to treat pain) in a timely manner. In addition, R15 did not receive the correct dose on 5/1/26 after the physician changed the order on 4/30/26.Findings include: The facility's Liberalized Medication Administration Policy, revised 2/12/24, indicates: Medications should be administered at appropriate times per pharmacy regulation. Medications ordered at prescribed times will be given as ordered. Between 5/3/26 and 5/5/26, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including neuropathy, chronic pain of both knees, and status post total right knee replacement. R15's Minimum Data Set (MDS) assessment, dated 5/11/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R15 had intact cognition. R15 was R15's own decision maker. On 5/3/26 at 10:33 AM, Surveyor interviewed R15 who stated R15 had not received R1's AM medications and was still waiting for a pain pill. In a subsequent interview on 5/4/26 at 9:10 AM, R15 stated R15 had neuropathy which affected R15's feet. R15 stated R15 took gabapentin 3 times daily at home but spaced it out so it worked consistently. On 5/3/26 at 10:55 AM, Surveyor observed Registered Nurse (RN)-K provide medication to R15. R15's medical record contained an order for 400 milligrams (mg) of gabapentin for osteoarthritis three times daily (dated 4/28/26). The medication was scheduled for 8:00 AM, 12:00 PM, and 4:00 PM. R15's Medication Administration Record (MAR) indicated the following: ~ On 4/29/26, R15's 8:00 AM dose of gabapentin was administered at 10:16 AM. ~ On 4/30/26, R15's 8:00 AM dose of gabapentin was administered at 10:02 AM. R15's medical record indicated R15 was seen by the physician on 4/30/26. R15's primary complaint was peripheral neuropathy in bilateral feet. Prior to hospitalization, R15 was on 900 mg of gabapentin three times daily which R15 stated worked well. R15's gabapentin was decreased to 400 mg three times daily in the hospital. The physician did not know why. R15 told the physician R15's neuropathy was bothersome and felt like pins and needles in both feet that caused R15 to feel restless. The physician changed R15's gabapentin order on 4/30/26. The physician discontinued the 400 mg of gabapentin and prescribed 600 mg of gabapentin three times daily for 3 days and then 800 mg three times daily. R15's MAR indicated R15 received 1000 mg of gabapentin three times on 5/1/26. R15 was administered 400 mg and 600 mg during the AM, noon, and PM medication passes. On 5/3/26, R15's 8:00 AM dose of gabapentin was administered at 10:57 AM. The 12:00 PM dose was administered at 1:22 PM which was 2 hours and 25 minutes after the first dose. On 5/4/26 at 1:33 PM, Surveyor interviewed Director of Nursing (DON)-B who was not previously aware of any medication errors for R15 and confirmed the wrong dose of gabapentin was provided on 5/1/26. DON-B stated staff must not have discontinued the previous dose as ordered by the physician and administered the 400 mg and 600 mg doses that day. When Surveyor informed DON-B about the late gabapentin doses, DON-B confirmed if a medication is prescribed at a certain time, the medication should be administered within one hour prior to or after the scheduled time. DON-B stated if a medication is administered late, staff should ensure the next dose is provided at an equal interval to the scheduled time.