STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525307	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Green Bay	2961 St Anthony Dr Green Bay, WI 54311

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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
	525307	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Green Bay	2961 St Anthony Dr Green Bay, WI 54311

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 0697 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 staff and resident interview and record review, the facility did not ensure pain medication was provided timely for 1 resident (R) (R4) of 3 sampled residents.R4 received Hospice services and had an order for as needed (PRN) morphine for pain. On either 7/8/25 or 7/20/25, R4 requested PRN pain medication. R4 did not receive the medication timely. Findings include:The facility's Pain Management and Assessment policy, revised 4/25/25, indicates: The purpose of this policy is to develop a standardized method for assessing, monitoring, evaluating, managing, and documenting pain in both cognitively intact and impaired residents. Residents will receive necessary comfort, exercise greater independence, and enhance dignity through optimizing their ability to perform activities of daily living. On 8/18/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including lung cancer, brain cancer, encounter for palliative care, chronic obstructive pulmonary disease (COPD), and generalized anxiety disorder. R4's Minimum Data Set (MDS) assessment, dated 6/20/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition. R4 received Hospice services. R4 had the following orders: ~ 0.5 milliliters (ml) of morphine sulfate (concentrate) oral solution 20 mg/milliliter (ml) by mouth every hour as needed for pain or shortness of breath. ~ 0.25 ml of morphine sulfate oral solution 20 mg/ml every hour as needed for pain or shortness of breath.On 8/18/25 at 10:45 AM, Surveyor interviewed R4 who indicated sometimes R4 did not get pain medication timely. R4 indicated it took staff 2 hours to provide R4's as needed (PRN) morphine approximately 1 month ago. R4 indicated R4 told staff that R4 was upset that it had taken so long to receive the medication. R4 could not recall the date or the nurse who administered the medication. In a subsequent interview at 3:55 PM, R4 indicated R4's stomach was bothering R4 and R4's ass was on fire the day R4 had to wait 2 hours to receive morphine. R4 indicated R4 was not a drug user and only asked for morphine when it was needed. A progress note, dated 7/20/25, indicated R4 had constipation issues. R4 received Miralax at 12:06 PM which was documented as ineffective at 3:57 PM. The facility contacted R4's Hospice provider who prescribed a one time dose of Senna which was effective.On 8/18/25 at 1:00 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated approximately 1 month ago it took the nurse a long time to administer R4's pain medication. LPN-D indicated 2 nurses worked the floor and usually split R4's wing. LPN-D indicated the Certified Nursing Assistants (CNAs) used walkie talkies to notify the nurses that R4 had requested pain medication. LPN-D indicated R4 was not LPN-D's resident and LPN-D thought the other nurse administered the medication. LPN-D indicated a CNA approached LPN-D a while later and indicated R4 was still waiting for medication. LPN-D assessed R4 who indicated R4 had been waiting 2 hours for pain medication. LPN-D notified the other nurse who provided R4's pain medication.On 8/18/25 at 2:00 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who was not aware that R4 did not receive pain medication timely. ADON-C indicated the nurse should have reported the information to ADON-C.On 8/18/25 at 2:42 PM, Nursing Home Administrator (NHA)-A and ADON-C indicated to Surveyor that a grievance was started for the concern that R4 had not received PRN pain medication timely. ADON-C indicated ADON-C spoke with LPN-D and they narrowed the date down to either 7/8/25 or 7/20/25. On 7/8/25, R4 received Tylenol. On 7/20/25, R4 received PRN morphine at 8:30 AM which was documented as effective. ADON-C later provided Surveyor with the phone number of the nurse who worked with LPN-D and administered pain medication to R4 on both dates. Surveyor left a message with the nurse but did not receive a return call. ADON-C indicated staff should have filled out a grievance form and indicated ADON-C would provide staff education. In a subsequent interview at 4:01 PM, ADON-C indicated when PRN pain medication is requested, the nurse should finish what they are doing and provide the medication to the resident.