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	05/20/2026

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 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 interview and record review, the facility did not ensure assessments and daily skilled/alert charting was completed for 2 residents (R) (R7 and R12) of 13 sampled residents.R7's medical record did not contain assessments on 5/14/26 and 5/19/26 to ensure R7 was monitored and evaluated post-fall.R12 was admitted to the facility without initial nursing assessments to determine R12's required level of assistance.Findings include:The facility's Fall Prevention, Post Fall, and Communication policy, dated 1/21/26, indicates: Purpose: To promote resident safety by identifying fall risk, implementing individualized fall-prevention interventions, ensuring timely post-fall evaluation, and reviewing outcomes to prevent recurrence .Post fall response: .2. Monitoring and re-evaluation: Document on resident's condition at a minimum of every shift for 72 hours. Staff should document relevant post-fall clinical findings, such as vital signs, pain, swelling, bruising, and changes in function or cognitive status. Staff will have increased awareness that the resident has recently fallen and report any changes in function, increased pain, and changes in cognition to the nurse for further evaluation. Monitor for signs of head injury, including but not limited to reduced level of consciousness, lethargy, significant weakness in one or more of the extremities, and rapid deterioration in neurological function .1. Between 5/19/26 and 5/20/26, Surveyor reviewed R7's medical record. R7 had diagnoses including schizoaffective disorder, bipolar type, Takotsubo syndrome (a condition in which the heart muscle weakens suddenly, often mimicking a heart attack but without a blockage in the coronary arteries), epilepsy, and diabetes type II. R7's care plan, initiated 4/30/26, indicated R7 was at moderate risk for falls related to impaired balance, amputation, and psychotropic medication use.R7's medical record indicated R7 fell on 4/28/26, 5/12/26 (3 times), 5/13/26, and 5/19/26 but did not contain post-fall assessments on 5/14/26 and 5/19/26.(See interview under example 2.)2. Between 5/19/26 and 5/20/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including diabetes type II, chronic kidney disease (CKD), sepsis, hypertension, and major depressive disorder. A progress note, dated 5/6/26 at 11:38 AM, indicated R12 arrived at the facility in a wheelchair via flexible transport. R12 was alert and oriented and transferred with the assistance of one staff into bed. Surveyor noted there was no other admission documentation in the progress note, including diagnoses, nursing assessments (including a skin assessment), vital signs, antibiotic medication prescribed for infection, other high-risk medications, or that R12 required assistance with activities of daily living (ADLs).Daily skilled charting, dated 5/7/26 at 10:17 PM (approximately 34-1/2 hours later), indicated R12 had osteomyelitis of the left lower extremity, diabetes type II, sepsis, gout, fatty liver, anemia, major depressive disorder, acquired absence of left toe, hypertension, and gastroesophageal reflux disease (GERD). R12 remained in bed all shift and refused to get up for meals. R12 ate all meals in bed and complained of left lower extremity pain. Oxycodone was administered and effective. R12 was alert and able to make needs known. The note indicated R12 had a periwound that measured 6.57 centimeters (cm) (length) x 1.52 cm (width) x 0.6 cm (depth) with a wound dressing (the wound location was not indicated) and a wound vac on a left lower ankle wound that measured 9.89 cm (length) x 2.33 cm (width) x 1.6 cm (depth).On 5/19/26 at 2:45 PM, Surveyor interviewed Registered (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (RN)-G who indicated alert charting is completed for falls. RN-G indicated monitoring is completed for antibiotics, new skin conditions, and for COVID-19 and other infections. RN-G did not know the last time RN-G completed a change of condition or admisssion assessment. RN-G indicated RN-G does not complete alert charting but completes the assessment and documents it in a daily skilled progress note. On 5/20/26 at 1:45 PM, Surveyor interviewed Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-F. ADON-F was not aware nurses were not completing alert/daily skilled charting, assessments (including post-fall assessments), and admission documentation. ADON-F verified nurses should complete alert/daily skilled charting on a daily basis and post-fall assessments once per shift. DON-B verified R7's medical record did not contain post-fall assessments on 5/14/26 and 5/19/26 per facility policy and indicated R12's admission documentation should have included more information to ensure R12 was assessed so staff could meet R12's needs. DON-B indicated nursing staff were focused on R12's suicidal ideation and not R12's medical needs. DON-B indicated R12's admission documentation was not in accordance with the facility's practice.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure monitoring of high-risk medications for 3 residents (R) (R7, R11, and R12) of 4 sampled residents.R7 was prescribed oral vancomycin (an antibiotic medication) for clostridioides difficile (C. diff) infection. R7's medical record did not indicate staff monitored R7 for adverse reactions to the high-risk medication.R11 was prescribed IV cephalexin (an antibiotic medication) for cellulitis. R11's medical record did not indicate staff monitored R11 for adverse reactions to the high-risk medication.R12 was prescribed IV ceftriaxone sodium (an antibiotic medication) for osteomyelitis and sepsis. R12's medical record did not indicate staff monitored R12 for adverse reactions to the high-risk medication.Findings include:The facility's Policy and Procedure Alert Charting, revised 11/13/24, indicates: Purpose: To provide guidance for documentation in the medical record for situations that meet the criteria of a change in condition, and incident/accident, or as otherwise clinically indicated .follow-up documentation is required for residents on antibiotic/anti-infective therapy for the duration of therapy .On 5/20/26 at 8:20 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated alert charting is required each shift to ensure monitoring for adverse reactions when a resident is prescribed antibiotics.1. Between 5/19/26 and 5/20/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of C. diff with prescribed antibiotic therapy. R7's medical record did not contain documentaton on 5/17/26 to indicate staff monitored R7 for adverse reactions to the antibiotic.2. Between 5/19/26 and 5/20/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] following hospitalization for sepsis secondary to urinary tract infection (UTI) and bilateral lower extremity cellulitis with an order for a 10-day course of IV cephalexin. R11's medical record did not contain documentation on 5/11/26 to indicate staff monitored R11 for adverse reactions to the antibiotic. 3. Between 5/19/26 and 5/20/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] with an order for IV ceftriaxone for osteomyelitis and sepsis. R12's medical record did not contain documentation from 5/10/26 through 5/12/26 to indicate staff monitored R12 for adverse reactions to the antibiotic.On 5/19/26 at 2:45 PM, Surveyor interviewed Registered Nurse (RN)-G who indicated staff monitor and complete alert charting for residents on antibiotics. RN-G indicated RN-G does not complete alert charting but completes an assessment and documents it in a daily skilled nursing progress note. On 5/20/26 at 1:45 PM, Surveyor interviewed Director of Nursing (DON)-B and Assistant Director of Nursing (ADON)-F. ADON-F indicated ADON-F was not aware nurses were not completing alert charting. ADON-F verified nurses should complete alert charting once per shift and monitor for adverse reactions when a resident is prescribed a course of antibiotics. DON-B verified R7, R11, and R12's medical records did not contain monitoring documentation for adverse reactions to antibiotic medication on the dates listed above. DON-B confirmed R7, R11 and R12 were admitted to the facility on antibiotic therapy and monitoring is required throughout the duration of antibiotic therapy.On 5/20/26 at 2:45 PM, and 3:45 PM, Surveyor requested the facility's policy on high-risk medication monitoring from DON-B. A policy was not provided.

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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 provide timely laboratory services for 1 resident (R) (R2) of 3 sampled residents. Nurse Practitioner (NP)-E ordered a potassium lab to be drawn for R2 by 3:00 PM on 3/25/26 due to a critical potassium blood level. The lab was not drawn until 3/26/26 at approximately 9:00 AM. Findings include: The facility's Physician Orders policy, revised 11/13/24, indicates physician orders will be transcribed and implemented in accordance with professional standards. On 5/19/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including paraplegia, pneumonia, diabetes, cirrhosis of the liver, and anxiety. R2's Minimum Data Set (MDS) assessment, dated 4/13/26, stated R2's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating intact cognition. R2 discharged from the facility on 5/6/26. Surveyor reviewed R2's Treatment Administration Record (TAR) and lab reports. Lab results, dated 3/25/26 at 6:44 AM, indicated R2's potassium level was 2.7 millimoles/liter (mmo/L) (the normal range is 3.5-5.1 mmo/L). R2's TAR contained an order for a potassium level draw re-check for hypokalemia (low potassium) on 3/25/26 at 3:00 PM. The order was not initialed as completed. On 5/20/26 at 8:40 AM, Surveyor interviewed NP-E who stated R2 had a critically low potassium level on 3/25/26 and NP-E instructed staff to give oral potassium and re-check R2's potassium level at 3:00 PM on 3/25/26. NP-E noted the order was not completed and faxed the facility on 3/26/26 stating R2 had a critically low potassium on 3/25/26 and an order was given to re-check R2's potassium level by 3:00 PM on 3/25/26. NP-E stated the re-check was not done which was unacceptable. NP-E also stated it is imperative the facility ensures orders are followed when a resident has a critical lab value so it does not result in hospitalization. NP-E ordered a STAT (immediate) potassium level and to update NP-E with the results. NP-E stated there have been concerns with labs not being completed timely in the past. NP-E stated symptoms of low potassium can include irregular heart rate/palpitations and fatigue. On 5/20/26 at 9:19 AM, Surveyor interviewed Registered Nurse (RN)-C who stated RN-C received the verbal order from NP-E to give R2 oral potassium and draw a potassium lab at 3:00 PM on 3/25/26. RN-C stated RN-C gave R2 the oral potassium and transcribed the lab order in R2's TAR. RN-C also updated Licensed Practical Nurse (LPN)-D who was the PM supervisor on 3/25/26. RN-C stated RN-C worked on 3/26/26 and noted the lab had not been drawn on 3/25/26 as ordered. On 5/20/26 at 9:55 AM, Surveyor interviewed LPN-D who indicated R2's potassium lab had to be drawn by 3:00 or 4:00 PM on 3/25/26 but stated the order RN-C entered did not specify a time. LPN-D stated by the time LPN-D completed medication pass on 3/25/26, it was after 6:00 PM so the lab was not drawn. On 5/20/26 at 1:40 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the lab was drawn on 3/26/26 (not 3/25/26 as ordered). DON-B stated several nursing staff are able to draw labs throughout the day and if they are unable to get the lab, they request an order to send the resident to the hospital to draw the lab if needed. DON-B was not sure why R2's potassium lab was not drawn on 3/25/26 per the physician's order.