

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook of Green Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the right to make healthcare decisions was provided for 1 resident (R) (R1) of 1 sampled resident. R1 had an activated Power of Attorney for Healthcare (POAHC). R1's medical record contained multiple documents signed by a family member who was not their POAHC. The facility did not have authorization to allow someone other than R1's POAHC to make medical decisions on their behalf. Findings include: R1 was admitted to the facility on [DATE]. A Minimum Data Set (MDS) assessment, dated 6/30/26, stated R1 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. R1's medical record contained an activated POAHC document that designated POAHC-C as R1's primary decision maker. R1's medical record contained the following documents that were signed by Family Member (FM)-D without authorization or declination to act from POAHC-C: ~ Consent and authorization to treat dated 3/2/26~ Consent for bupropion dated 3/7/26~ Consent for trazodone dated 3/7/26~ Consent for fluoxetine dated 3/7/26~ Consent for Lamictal dated 3/7/26~ Do Not Resuscitate (DNR) paperwork dated 3/2/26 On 7/14/26 at 10:46 AM, Surveyor interviewed Social Services (SS)-E who stated FM-D informed the facility that they were the primary POAHC for R1. FM-D verified R1's POAHC document listed POAHC-C as their POAHC. SS-E stated when the facility does not receive a response from a POAHC, their policy is to send a letter and/or email and contact Adult Protective Services if needed. On 7/14/26 at 11:20 AM, Surveyor interviewed R1 who stated their primary POAHC for medical decisions is POAHC-C. On 7/14/26 at 9:50 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated it was identified during R1's 6/30/26 hospitalization that the facility did not have the right contact information for R1's primary POAHC.		

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	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 interview and record review, the facility did not ensure 1 resident (R) (R2) of 11 sampled residents received care and treatment in accordance with their plan of care. The physician was not notified when R2's blood pressure (BP) was outside the ordered parameters. The provider indicated they would have instructed staff to recheck R2's BP, notify their cardiologist, and monitor their symptoms which were not completed. Findings include: The American Heart Association defines a low blood pressure as under 90/60 millimeters of mercury (mm/Hg). The facility's Change of Condition policy, revised 11/13/24, indicates: The physician and power of attorney/responsible party will be notified when there has been a change that is sudden in onset, that is a marked difference in usual signs/symptoms, and/or the signs/symptoms are unrelieved by measures already in place. Specific information that requires prompt notification includes, but is not limited to: a. Significant change or instability of vital signs .r. Instructions to notify the physician of changes in the resident's condition .3. The nurse will complete an assessment and document the findings in the resident's record, including but not limited to vitals signs, pain, respiratory status, and cardiac status as applicable. Notification of the medical professional and resident representative will be documented in the medical record .9. The care plan will be updated as necessary. R2 was admitted to the facility on [DATE] and had diagnoses including hypertensive heart disease with heart failure, paroxysmal atrial fibrillation, presence of automatic cardiac defibrillator, chronic obstructive pulmonary disease, and chronic combined systolic and diastolic heart failure. On 7/13/26, Surveyor reviewed R2's medical record. Physician orders indicated staff should check R2's BP daily. R2 was under the care of a cardiologist. R2's medical record did not contain a cardiac-specific care plan. On 7/13/26 at 1:15 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-H who stated R2 had swelling of the arms, legs, and feet. R2's edema was significant enough that the physician prescribed 120 milligrams (mg) of Lasix daily for a period of time and was monitoring kidney function. ADON-H stated the facility planned to transfer R2 to an assisted living facility; however, R2's heart failure had declined and they were not comfortable with the transfer. R2 then had a stroke and was transferred to the hospital on 7/2/26. R2 did not return to the facility. R2's medical record indicated they had a BP of 78/55 mm/Hg on 3/4/26. The medical record did not contain a repeat BP or indicate the physician was notified. On 7/14/26 at 12:53 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the physician should be contacted for a critical blood pressure level. DON-B indicated a critical level would be if a resident was getting down in the 90s over 50s/60s. Upon reviewing R2's medical record, DON-B stated R2's blood pressure parameters were 80-170 for systolic and 50-100 for diastolic. DON-B confirmed R2 had a BP of 78/55 mm/Hg on 3/4/26 and stated Unit Coordinator (UC)-F entered the BP in the medical record. On 7/14/26 at 1:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R2's medical record did not indicate the physician was notified, a repeat BP was obtained, or contain monitoring instructions for R2. On 7/14/26 at 3:51 PM, Surveyor interviewed UC-F who recalled the day in question because there were 2 residents who had low BP at the same time. UC-F thought Nurse Practitioner (NP)-G was notified and told UC-F to monitor for symptoms, including lethargy, nausea, light-headedness, and palpitations and to call cardiology for any symptoms. UC-F stated they thought they passed on the instructions to the next shift nurse. UC-F confirmed they did not document the call or instructions to monitor for symptoms in R2's medical record. (It was confirmed the facility's 24-hour nursing report did not contain documentation either.) On 7/14/26, Surveyor reviewed R2's care plan which did not include instructions on what to do if their BP was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside the ordered parameters. On 7/14/26 at 4:33 PM, Surveyor interviewed NP-G who stated R2 had a pacemaker, had low BPs intermittently, and was being closely monitored around the time of the low BP on 3/4/26. NP-G stated if the facility notified them of a low BP, NP-G would have told them to complete a follow-up BP and monitor R2 for symptoms. NP-G stated there was a lot going on with R2's medication and they blew up like a balloon at one point (related to fluid). NP-G stated they would have instructed staff to include the cardiologist and would have made sure a repeat BP was taken in case the wrong cuff size was used. On 7/15/26 at 8:00 AM, Surveyor interviewed DON-B who confirmed R2's medical record did not indicate a repeat BP was obtained or indicate the cardiologist was notified of the low BP. DON-B also confirmed there was no documentation to alert the following shifts of R2's low BP, monitoring instructions, or the need to contact the cardiologist.		