STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525319	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Lakeside	2115 E Woodstock Pl Milwaukee, WI 53202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility did not ensure they provided an environment free from accident hazards for 2 of 4 residents (R) reviewed for accidents and supervision (R59 and R110.) Certified Nursing Assistant (CNA)-E rolled R59 away from them while providing care in bed and R59 rolled out of bed on to the floor. The facility's investigation into the fall identified R59's specialty air mattress was not appropriately attached to the bedframe allowing the mattress to flip upright when R59 was rolled onto their right side causing R59 to fall. R59 suffered a L2 lumbar fracture as a result of the fall from the bed to the floor. R110 has been assessed to need the assistance of 1 staff member and a gait belt for safety for transfers. Surveyor observed R110 being transferred by 1 staff member without the use of a gait belt for safety. Evidenced by: 1.) R59 was admitted to the facility on [DATE] with diagnoses that included conversion disorder with seizures or convulsions, congenital deformity of knee, developmental disorder of scholastic skills, and morbid obesity. A review of the quarterly MDS (Minimum Data Set) dated 1/29/26, documents R59 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R59 is cognitively intact. R59 is assessed to have limited range of motion on 1 side of the upper extremity and impairment on both sides of the lower extremities. R59 is dependent on staff when rolling left to right, from lying position on her back while in bed. R59 is dependent on staff for Activities of Daily Living such as incontinence cares and personal hygiene. Surveyor conducted a review of R59's individual plan of care and noted the following: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) obesity, seizure, bipolar disorder, healing foot fracture, deformity of knee. Date Initiated: 05/14/2025. Revision on: 05/22/2025. Interventions include: Personal Hygiene/assist of one. Date Initiated: 05/14/2025 The resident has limited physical mobility r/t obesity and congenital deformity of knee. Date Initiated: 05/14/2025. Revision on: 05/14/2025. Interventions include:*Ambulation. Locomotion-wheelchair manual. Date Initiated: 05/14/2025*Bed mobility assist–Two. Date Initiated: 04/18/2026. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes this intervention was updated after R59's fall on 4/17/26.*PT (Physical Therapy) and OT (Occupational Therapy) eval (evaluation) and treatment per MD (Medical Doctor) orders. Date Initiated: 05/14/2025.*Transfer assist - sit-to-stand-Two. Date Initiated: 07/10/2025*Transfer assist-Two. Date Initiated: 05/14/2025 The resident is at risk for falls r/t repeated falls, osteoarthritis, fibromyalgia. Date Initiated: 05/14/2025. Revision on: 04/19/2026. (Surveyor notes this care plan was updated after R59's 4/17/26 fall.)Interventions included:*I will be free from further incident/falls through the review date. Date Initiated: 05/14/2025.*4/17-ED (Emergency Department) to eval (evaluate) and tx (treat). Bed rearranged to promote safety. PT/OT to eval and treat for positioning. Air mattress discontinued. Resident changed to a 2 person assist with bed mobility. Date Initiated: 04/17/2026. Surveyor notes this intervention was updated after R59's fall on 4/17/26.*PT/OT to evaluate and treat. Date Initiated: 05/14/2025.*Gripper socks on when up. Date Initiated: 05/14/2025. R59 is at risk for alteration in skin integrity related to type two diabetes, obesity. Date initiated 5/14/25.Interventions included:* Use a pressure relieving cushion for my wheelchair and pressure reducing mattress to my bed. On 2/10/26, the facility completed a MORSE fall scale (a clinical tool used to assess a patient's likelihood of falling) for R59. R59 was assessed to be at moderate risk for falls. Nursing note dated 4/17/2026 at 10:07 PM, documents around 9pm, writer (Assistant Director of Nursing-C) was called into resident's room, R59 had witnessed fall. Resident assessed, PERRLA (Pupils Equal, Round, and Reactive to Light) intact, resident remains A&Ox4 (alert and oriented times four,) C/O (complaint of) 8/10 pain to right arm and right leg. R59 requesting to go to ER. [Name of transport company] ambulance notified. Vitals: BP (blood pressure) 118/82, HR (heart rate) 86, SPO2 (oxygen saturation) 97%, RR (respiratory rate) 18. R59 assisted to back side. ROM (Range of Motion) passively provided, and able to move WNL (within normal limits.) [Name of transport company] ambulance arrived, R59 transported to [name of hospital] around 9:45 PM. Verbal bed hold obtained, resident unable to sign. R59's mother updated, Physician on call notified, NHA (Nursing Home Administrator)-A, and DON (Director of Nursing)-B notified. Nursing Note dated 4/18/2026, at 2:17 AM, (R59) Back from ER, alert and awake, denies pain at this time. Has L2 lumbar fx (fracture) per ER report, pt (patient) to follow up with Neurologist. BP 129/77, HR 69, pox 98, on RA, temp 98.7. support provided. Nursing note dated 4/18/2026, at 6:10 AM, CT (Computed Tomography) results received from hospital. Fracture of the L2 vertebral body. It is unclear if this is acute or chronic. NHA-A notified. Surveyor conducted a review of the after-visit summary dated 4/17/26 and provided by the hospital. The summary stated R59 injured multiple areas with her fall today but the only area that is broken is the L2 vertebra in the lower back. This should heal with time without surgery. However, it does need follow-up with the neurosurgeon to monitor the area as it heals. The ribs, shoulder, hip etc. had negative x-rays and are just bruised. R59 may use prescribed medications for pain. Continue other home medicines as prescribed. Follow-up with primary care provider for recheck of other areas of injury/pain. Return to emergency room as needed for new or worsening concerns. You (R59) have a crushed vertebra. This is a compression fracture of one or more bones in your spine. This kind of break usually happens in older people with thinning of the bones called osteoporosis. It may happen after a ground-level fall or even with a very minor force. This means the spine doesn't need to be (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	surgically realigned or fused. And it usually doesn't cause any injury to the spinal cord or nerves. The injury often takes 1 to 3 months to heal. It can be treated at home with short-term bed rest and pain medicine. A back brace or abdominal binder may be prescribed. This reduces pain by limiting motion at the fracture site. Surveyor conducted a review of the facility's Misconduct Incident Report submitted to the State Survey Agency on 4/24/26. The report documents that on 4/17/26 at approximately 9:00 PM, R59 sustained a witnessed fall from bed while receiving cares from CNA (Certified Nursing Assistant)-E. At the time of the incident, R59's care plan identified R59 as requiring an assist of one staff for cares and staff was following the current care plan. R59 sustained a fracture of lumbar spine. The incident summary documents R59 was positioned on her right side facing the window. The bed positioned against the window wall. Staff reported the bed suddenly lifted on the window side, causing R59 to fall to the floor. Staff immediately called for assistance and 911 was contacted and R59 was transported out to the emergency department for further evaluation. The Investigation findings document a post-incident inspection identified a broken plastic clip securing the air mattress strap to the frame on R59's left side. The mattress was immediately removed from service and replaced. R59 was reassessed following the fall. R59's level of assist was updated from assist of one to assist of two. R59's care plan was revised accordingly. Corrective Actions documented, all facility air mattresses were inspected for defects, securement clips, and proper function. All beds were inspected for proper functionality. Any identified variances were corrected immediately. Residents utilizing air mattresses were reassessed for level of assistance needs, their care plans updated as indicated. Maintenance system was updated to include preventative maintenance checks on air mattress tie-down clips and functionality. The incident investigation identified a failed mattress securing clip during equipment inspection. Surveyor notes the facility's investigation included a signed statement from Maintenance Director-D, dated 4/19/26, documenting the Maintenance Department inspected all air mattress beds to ensure the plastic tie down clips were not cracked or broken and functioning as intended. The inspection of tie down clips was added to the Maintenance Department PM log under the Tels system. Surveyor did request to review the PM log in the Tels system and was not provided a log for inspection of tie down clips completed by the Maintenance Department. Surveyor conducted a review of the facility's fall investigation dated 4/17/26 which documents writer (Assistant Director of Nursing (ADON)-C) was called into room by CNA due to resident rolling out of the bed during cares. Upon entering room, the resident was on the floor. The resident was noted between the right side of the bed and the heater. The air mattress was off of the bed frame, and left side in the air, and leaning against the wall. Writer removed everything in the way including the bed and air mattress. Resident was lying completely on her right side, with her head in the air. Her shoulders protected her head from hitting the ground. R59 stated, I don't know what happened. Writer assisted R59 back onto back. R59 complained of pain to right arm and right leg. R59 was asked to lift arms, R59 unable to independently lift right arm. Writer provided passive range of motion, R59 stated ouch. R59 rated pain 8/10. Ambulance called and R59 transported to hospital. On 4/20/26, the investigation included a root cause. Root Cause: Cares were being performed and resident air mattress flipped up and R59 slid off the bed to the floor. Intervention: Immediately sent to emergency department for eval and mattress changed while at emergency department. Permanent intervention regular mattress and room rearranged. On 6/1/26, at 12:05 PM, Surveyor interviewed Director of Maintenance (DM)-D regarding routine maintenance of resident beds and mattresses. DM-D stated the maintenance department will put a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	new mattress in place, such as a specialty air mattress, when requested by nursing. DM-D stated the specialty air mattress has 3 straps on each side that are clipped together around the bed frame. There would be a total of 6 straps holding the air mattress in place on the bed frame. Surveyor asked DM-D if he was aware R59's air mattress had a broken clip. DM-D stated he was not aware and if 1 clip was broken, the other clip/straps would still hold the mattress in place. DM-D stated he does not routinely check the beds and air mattress after they put them in place for resident use. DM-D stated the nursing staff are the eyes and ears and would notify the maintenance department if something was broken or not working properly. On 6/1/26, at 1:40 PM, Surveyor interviewed CNA-E who provided cares to R59 on 4/17/26. CNA-E stated R59's plan of care allows for 1 staff person to provide cares to R59. R59 needs the assistance of 2 staff for transfers. CNA-E stated R59 was lying in her bed when she rolled R59 towards the window to finish providing incontinence cares. CNA-E stated it happened so quickly when R59 was rolling over she rolled off of the bed onto the floor. R59 is heavier and the motion of the fall caused the bed to move towards CNA-E, and she couldn't grab R59 fast enough to prevent the fall. CNA-E stated the air mattress never came off of the bed frame, but the bed did move, resulting in R59 lying on the floor between the bed and the wall. CNA-E stated she was not aware there was a broken clip on the air mattress. CNA-E stated R59 is now 2 staff assist for cares and this is much better for everyone. According to https://www.pioneernetwork.org/wp-content/uploads/2018/07/Restorative-Transfers.pdf: Dependent Roll - Set-up - Make sure that the resident has plenty of room on the side direction he/she wishes to roll. Pre-roll Positioning - The person assisting positions him/herself on the side of the bed toward which the resident is to roll. Cross the lower leg farthest away from you over the extremity closest to you. Cross the arm farthest away from you over the chest, supporting the arm as necessary. Place one hand on the back of the pelvis and one hand on the shoulder blade. Roll - Gently roll the resident toward you onto his/her side. Encourage the resident to turn his/her head in the direction of the roll. Position arms and legs with pillows as needed. Encourage the resident to assist in the following ways: Flexing the opposite hip and knee, placing the foot flat and aiding the roll by reaching forward with the pelvis. Turn the resident's head in the direction of the roll. If the roll is toward the affected side, have the resident place his/her unaffected arm in the direction of the roll. If the roll is toward the unaffected side, have the resident clasp his/her hands together (as in praying), and reach with both arms in the direction of the roll. The Headmaster (WI Nurse Aide Candidate Handbook) mock skills for peri-care document includes: The test observer stands on the side of the bed where the rail would have been raised. The test observer doesn't move there until the candidate tells them to, so it is clear the candidate was thinking of what safety precautions need to be in place before starting the skill. So, if there was no side rail raised, a second staff member would have to be present on that side of the bed for safety. On 6/1/26, at 2:07 PM, Surveyor interviewed ADON-C regarding R59's fall from bed on 4/17/26. ADON-C stated when she arrived to R59's room, R59 was observed on the floor between the bed and the window, and the air mattress was flipped up and remained in the air. ADON-C stated they moved items out of the way, the bed and air mattress, to get to R59 and roll her onto her back. R59 did complain of pain to the right arm and leg. R59 was immediately transported out for further evaluation. Surveyor questioned ADON-C again about the air mattress and the position after the fall. ADON-C stated the air mattress was definitely upright and not on the bed frame. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes CNA-E rolled R59 towards the window, away from CNA-E to complete incontinence care. R59 was being rolled and rolled off the bed on to the floor. Surveyor also notes CNA-E stated the air mattress never came of R59's bed which conflicts with ADON-C's account of the incident. ADON-C was called to the room following R59's fall. ADON-C statement after the fall documents the resident was on the floor, noted between the right side of bed and heater. The air mattress was off of the bed frame, left side in the air. ADON-C confirmed to Surveyor in an interview that R59 was on the floor when she arrived to the room and the air mattress with upright and not on the bed frame. On 6/1/26, at 2:45 PM, Surveyor made observations of R59's room arrangement and bed/mattress while R59 was out of the room. R59's head of the bed was now against the wall with the window, and the left side of the bed was up against the wall. It was noted there was a bariatric mattress (48 inches wide) on a twin-size bedframe. Surveyor observed the mattress was hanging over the bedframe, on the left side, approximately 5 inches. The entire left side of the mattress was not supported by the bedframe and could easily be lifted up on the bedframe. The entire mattress was easily moved from the bed frame as it was not appropriately attached and too big for the bed frame itself, preventing it from fitting in the bed frame brackets. This made for an unsafe environment for R59 as the mattress could fall off the bedframe if R59 rolled to her left side. On 6/1/26, at 3:13PM, Surveyor interviewed DM-D and asked if he could confirm Surveyor's observation regarding R59's mattress being too large for the frame. DM-D confirmed that after R59 fell from the bed on 4/17/26, the air mattress was replaced with a regular pressure reduction mattress. DM-D stated the bedframe itself was not switched out. DM-D confirmed the mattress that was currently on R59's bed was a bariatric mattress that was 48 inches wide. DM-D confirmed the mattress must fit in between the bed frame brackets in order for it to be secure. During this observation, DM-D confirmed that no one in the maintenance department had been up to adjust R59's bedframe, although the bedframe had been adjusted after Surveyor's observation at 2:45 PM on 6/1/26. The mattress was now positioned correctly as the bedframe itself had been widened. DM-D stated he does not regularly get into each resident's room and depends on staff to alert him if there is something not working properly. On 6/1/26, at 3:30 PM, Surveyor interviewed Nursing Home Administrator-A and DON-B regarding Surveyor's observation of R59's mattress being too large for the bedframe with a 5-inch overhang on the side (width) of the bed being observed. Nursing Home Administrator-A and DON-B stated they had not been in R59's room to observe the bedframe. At this time, Surveyor stated there are additional safety concerns for R59 and the bed was a continued accident hazard. Nursing Home Administrator-A was asked if the facility is conducting routine maintenance on resident beds. Nursing Home Administrator-A stated he would provide Surveyor with the Tells report that is used to log the resident bed checks completed by maintenance. As of the time of exit, the Tells report provided was a check for bed rail inspection. This inspection was conducted for 1 resident who uses a bed rail. As of the time of exit, the facility was unable to provide additional evidence they had provided a safe environment free of accident hazards for R59. R59 was placed in bed with an air mattress that had a broken clip/strap. When R59 was on their side and rolled away from CNA-E, the air mattress was said to have flipped upright, causing R59 to fall to the floor. This fall resulted in R59 fracturing the L2 vertebra. Surveyors made observations of R59's bed on 6/1/26 and the mattress was not properly fitted to the bedframe, potentially becoming an accident hazard for R59. 2.) The facility's policy titled Gait-Transfer Belt and last revised 1/17/22 documents under purpose: To transfer or ambulate an individual with lower extremity weakness safely. Under procedure (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Transfer from bed to chair, commode, or wheelchair documents 1. Wheelchair is next to the Resident's strong side. 2. Remove armrests and footrests or raise foot pedals if applicable. 3. Explain procedure to Resident. 4. Resident may assist by using bed rail, head of bed, or trapeze for support as assistant(s) help Resident to sit up on side of bed. 5. Remove your transfer/gait belt. 6. Stand close to Resident with your feet about 18 inches apart. 7. Place belt around Resident's waist; snug but not tight. Avoid ribs, hipbone, or breasts. 8. Assistants stand on either side of Resident facing each other if two person transfer is required. Assistant stands directly in front of resident if one person transfer. 9. Staying close to the Resident, the assistant(s) rock back and forth, synchronizing movements and weight shifting from one leg to the other while maintaining a backward pelvic tilt. Hips and knees are bent, and on the count of three, the Resident is lifted up with use of transfer/gait belt and assisted to chair. 10. The same principles of this process shall be used when transferring with assistance to bed, commode or other appliances or furniture. R110's diagnoses include polyneuropathy (simultaneous malfunction of many peripheral nerves in the body,) spinal stenosis (narrowing of the spaces within the spine which puts pressure on the spinal cord and nerves,) peripheral vascular disease (circulatory condition which narrows blood vessels reducing blood flow to the limbs,) unspecified visual loss, and history of falling. R110's Morse Fall scale assessment dated [DATE] has a score of 25 which indicates moderate risk for falling. R110's BIMS (Brief Interview for Mental Status) assessment dated [DATE] has a score of 11 which indicates moderate cognitive impairment. R110's physician progress note dated 5/28/26 under assessment and plan documents: male nursing facility resident with no past medical history with extensive foraminal stenosis and b/l (bilateral) lower extremity weakness. #Chronic BLE (bilateral lower extremity) weakness. # Peripheral neuropathy. # Limited mobility d/t (due to) above. R110's transfer and mobility evaluation dated 5/29/26 under the section for evaluation criteria and transfer method #3. 1 assist gait belt transfer, stand, and turn is checked for: a. Cooperative with transfer. b. Can follow directions/cues. c. Able to sit unassisted at side of bed. d. Needs assistance only from sitting to standing (no lifting). e. Bear full weight throughout entire transfer. R110's CNA (Certified Nursing Assistant) Kardex as of 6/2/26 under the mobility/transfer section documents *transfer assist – one. On 6/2/26, at 9:33 a.m., Surveyor observed R110 in the bathroom sitting on the toilet. Surveyor left R110's room. CNA-G stated to Surveyor I'm going in to help him and entered R110's room. On 6/2/26, at 9:34 a.m., Surveyor observed CNA-G in the bathroom with R110. CNA-G assisted R110 with standing by holding onto his back and telling R110 to hold onto the bar. CNA-G wiped R110 and pulled up R110's incontinence product and pants. CNA-G stated to R110 to turn around, asked R110 to place his hand on the armrest of the wheelchair and assisted R110 to sit in the wheelchair. CNA-G removed her gloves, wheeled R110's wheelchair over by his bed, placed the overbed table in front of R110, and call light within reach. Surveyor noted during this observation, CNA-G did not transfer R110 using a gait belt and observed a gait belt hanging on the wall next to R110's room door. On 6/2/26, at 9:38 a.m., Surveyor asked CNA-G if she should use a gait belt when transferring R110. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA-G replied yes. Surveyor stated to CNA-G, but you didn't use one. CNA-G replied to Surveyor, sorry about that. On 6/2/26, at 10:14 a.m., Surveyor asked Assistant Director of Nursing (ADON)-C if a resident is an assist of one for transferring should staff use a gait belt when transferring the resident. ADON-C replied yes. Surveyor informed ADON-C of the observation of CNA-G transferring R110 without a gait belt. On 6/2/26, at 10:22 a.m., Surveyor met with Director of Nursing (DON)-B and Regional Director of Clinical Services-H. Surveyor asked DON-B if a resident is an assist of one for transfers should staff use a gait belt when transferring the resident. DON-B replied yes. Surveyor informed DON-B and Regional Director of Clinical Services-H of the observation of R110 not being transferred with a gait belt.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 of 1 resident (R) on enhanced barrier precautions (R110.)On 6/2/26, Certified Nursing Assistant (CNA)-F and CNA-G did not wear appropriate personal protective equipment when providing morning cares and toileting with R110 who is on enhanced barrier precautions.Findings include:The facility's policy titled Enhanced Barrier Precautions and dated 3/26/24 documents under policy: It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with chronic wounds requiring a dressing, indwelling medical devices or residents with infection or colonization with an MDRO. Overview documents: Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDROs but will also address residents at risk for developing or becoming colonized. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions. Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities.High-Contact Resident Care Activities include: *Dressing, *Bathing/showering, *Transferring, *Providing hygiene, *Changing linens, *Changing briefs or assisting with toileting, *Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. *Wound care: any skin opening requiring a dressing.R110 was admitted to the facility on [DATE] with an unstageable deep tissue sacrum and left heel pressure injury.R110's diagnoses include polyneuropathy (simultaneous malfunction of many peripheral nerves in the body,) spinal stenosis (narrowing of the spaces within the spine which puts pressure on the spinal cord and nerves,) peripheral vascular disease (circulatory condition which narrows blood vessels reducing blood flow to the limbs,) unspecified visual loss, and history of falling.R110's at risk for wound infection care plan initiated and revised 5/26/26 includes an intervention of Enhanced Barrier Precautions for BLE (bilateral lower extremities) Partial Thickness Wounds R (greater than) >L. Initiated and revised 5/26/26.On 6/1/26, at 10:10 a.m., Surveyor observed an EBP (enhanced barrier precaution) sign on R110's room door.On 6/1/26, at 10:12 a.m., Surveyor observed R110 sitting in a wheelchair in his room. Next to the dresser in R110's room there is a PPE (Personal Protective Equipment) cart.R110's Certified Nursing Assistant (CNA) Kardex as of 6/2/26 under the section safety/monitor documents: *Enhanced Barrier Precautions for BLEs Partial thickness wounds R>L.On 6/2/26, at 7:26 a.m., Surveyor observed R110 sitting on the edge of the bed with his bare feet resting on the floor.On 6/2/26, at 7:33 a.m., Surveyor observed CNA-F and CNA-G enter R110's room and place gloves on. CNA-F asked R110 if he was wet. R110 touched the brief covering his frontal area and replied yes. CNA-F then asked R110 if it's okay with the bed going up so she can oil his legs. R110 replied yes. CNA-F raised the height of R110's bed and applied lotion to R110's bilateral lower extremities. CNA-F placed a pull up incontinence product and jeans up to R110's knees and lowered the bed down. CNA-F removed R110's gown and T-shirt. CNA-F handed R110 a wet washcloth asking R110 if he could wash his face. After R110 washed his face, CNA-F wiped R110's head with the wet washcloth. CNA-G handed CNA-F a partial wet bath towel. CNA-F washed R110's upper body, applied deodorant, and placed a T-shirt on R110. CNA-F ripped the sides of R110's incontinence product, R110 washed his frontal area. CNA-F had R110 roll on his side and the incontinence product was removed. CNA-F washed R110's rectal area and buttocks and applied barrier cream. CNA-F pulled up the incontinence product stating, Lets not pull up pants as they are going to do wound care. CNA-F asked R110 to scoot up in the bed, raised the head of the bed, and covered R110 with sheet. CNA-F placed soiled items in a cart outside R110's room, removed her gloves, and washed her hands. Surveyor (continued on next page)

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	525319	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Lakeside	2115 E Woodstock Pl Milwaukee, WI 53202

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted during this observation CNA-F only had gloves on and did not wear a gown.On 6/2/26, at 8:23 a.m., Surveyor observed Infection Control Preventionist (ICP)-K place an EBP sign on R110's door. Surveyor asked ICP-K why there wasn't a sign on the door this morning. ICP-K replied, we have some residents that like to take it off, it was there yesterday. Surveyor asked ICP-K if R110 should be on enhanced barrier precautions. ICP-K replied yes.On 6/2/26, at 9:30 a.m., Surveyor asked CNA-F if R110 is on any precautions. CNA-F replied, not that I'm aware of. Surveyor asked CNA-F if R110 is on enhanced barrier precautions. CNA-F replied, not that I'm aware of. On 6/2/26, at 9:31 a.m., Surveyor observed CNA-F ask Assistant Director of Nursing (ADON)-C if R110 is on EBP. ADON-C replied yes.On 6/2/26, at 9:33 a.m., Surveyor observed R110 in the bathroom sitting on the toilet. Surveyor left R110's room. CNA-G stated to Surveyor I'm going in to help him and entered R110's room.On 6/2/26, at 9:34 a.m., Surveyor observed CNA-G wearing gloves in the bathroom with R110. CNA-G assisted R110 with standing by holding onto his back telling R110 to hold onto the bar. CNA-G wiped R110 and pulled up R110's incontinence product and pants. CNA-G stated to R110 to turn around, asked R110 to place his hand on the armrest of the wheelchair, and assisted R110 to sit in the wheelchair. CNA-G removed her gloves, wheeled R110's wheelchair over by his bed, placed the overbed table in front of R110, and call light within reach. During this observation, Surveyor noted CNA-G was not wearing a gown.On 6/2/26, at 9:37 a.m., CNA-G stated to Surveyor, I forgot to put gown on. I was in a rush to get him off (referring to the toilet.)On 6/2/26, at 10:15 a.m., Surveyor asked ADON-C if R110 is on enhanced barrier precautions. ADON-C replied yes. Surveyor informed ADON-C of the observations of CNA-F and CNA-G not wearing the appropriate PPE while providing cares to R110.On 6/2/26, at 10:21 a.m., Surveyor met with Director of Nursing (DON)-B and Regional Director of Clinical Services-H. Surveyor asked DON-B if a resident is on EBP what is the expectation. DON-B informed Surveyor standard PPE for enhanced barrier precautions. Surveyor asked what this is. DON-B informed Surveyor she would have to check a sign, so she doesn't mis speak off memory. Surveyor asked DON-B if she could check an EBP sign. DON-B left the conference room and returned a minute later. At 10:22 a.m., DON-B informed Surveyor gloves and gown and then read the tasks off the sign when it is necessary. Surveyor then informed DON-B and Regional Director of Clinical Services-H the observations of staff not wearing appropriate PPE when providing cares to R110.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure proper inspection of resident's beds for 2 (R110 & R59) of 5 beds. *A gap of approximately five inches was observed between R110's air mattress and foot board on 6/1/256 & 6/2/26. *On 4/17/26, staff reported R59's bed suddenly lifted on the window side causing R59 to fall on the floor. Post-incident inspections identified a broken clip securing the air mattress strap to R59's bed frame. There is no evidence that R59's bed was inspected after the air mattress was placed. On 6/1/26, surveyors observed approximately five inches of R59's mattress was not supported by the bed frame on the left side. Findings include: R110 was admitted to the facility on [DATE] with diagnoses which include polyneuropathy (simultaneous malfunction of many peripheral nerves in the body), spinal stenosis (narrowing of the spaces within the spine which puts pressure on the spinal cord and nerves), peripheral vascular disease (circulatory condition which narrows blood vessels reducing blood flow to the limbs), unspecified visual loss, and history of falling. R110's physician order dated 5/29/26 documents: Air mattress setting 150 based on resident's weight. May be adjusted per preference every shift for wound care. On 6/1/26, at 10:12 a.m. surveyor observed R110's bed. Surveyor observed there is approximately a five-inch gap between R110's air mattress and foot board. On 6/1/26, at 11:54 a.m., surveyor observed there continues to be an approximate five-inch gap between R110's air mattress and foot board. On 6/1/26, at 12:15 p.m., surveyor asked Maintenance Director (MD)-D who ensures air mattresses properly fit a resident's bed. MD-D replied that would be us. MD-D explained air mattresses and bed are seven feet long unless it is a larger bed and then there is a foam insert that goes in there if the footboard is extended. Surveyor asked who puts the foam insert in. MD-D replied not me. Surveyor asked MD-D if he knew who did. MD-D replied no. On 6/1/26, at 1:19 p.m., surveyor observed there continues to be an approximate five-inch gap between R110's air mattress and foot board. On 6/2/26, at 7:16 a.m., surveyor observed R110 sitting on the edge of the bed with his bare feet on the floor. Surveyor observed there continues to be an approximate five-inch gap between R110's air mattress and foot board. On 6/2/26, at 9:20 a.m., surveyor asked Registered Nurse (RN)-I the process for a new admission receiving an air mattress. RN-I explained they normally get a report from the hospital. RN-I informed surveyor she would let her manager know and MD-D is very good at getting them a mattress. Surveyor (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked RN-I who ensures the air mattress is the right size for the bed. RN-I informed surveyor MD-D & Maintenance Assistant (MA)-L are very good and Assistant Director of Nursing (ADON)-M checks. Surveyor asked RN-I what she does if she observes a gap between the end of the mattress and foot board. RN-I informed surveyor she normally places a pillow until MD-D can let her know what to do. On 6/2/26, at 9:40 a.m., surveyor asked Licensed Practical Nurse (LPN)-J what the process is for a new admission receiving an air mattress. LPN-J informed Surveyor usually she checks with the manager, and they set it up when the new admission arrives. Surveyor asked LPN-J who ensures the mattress is the right size for the bed. LPN-J replied unsure, but I would think maintenance. On 6/2/26, at 10:04 a.m., Surveyor asked ADON-C what the process is for a new admission receiving an air mattress. ADON-C informed surveyor typically if they have a wound on the sacrum an air mattress is placed. ADON-C informed surveyor they like to see what therapy says for repositioning. Surveyor asked ADON-C how they obtain an air mattress. ADON-C they call maintenance; maintenance puts it on. Surveyor asked what happens if there is a gap between the end of the air mattress and foot board. ADON-C replied we let them know. Surveyor inquired who they let know. ADON-C replied maintenance. Surveyor asked if maintenance places something in the gap. ADON-C replied you'd have to ask them. Surveyor asked if nursing places anything in the gap. ADON-C replied no. At 10:17 a.m., surveyor asked ADON-C to accompany surveyor to R110's room. Before entering R110's room, ADON-C stated to surveyor I see what you mean. On 6/2/26, at 10:27 a.m., surveyor met with Director of Nursing (DON)-B and Regional Director of Clinical Services-H. Surveyor asked DON-B what the process is for a new admission receiving an air mattress. DON-B informed surveyor if they are alerted before an air mattress is placed by maintenance before their arrival. If the mattress was not caught by admission, then the mattress is switched out as quickly as possible by maintenance. Surveyor asked DON-B who ensure the mattress fits the bed frame. DON-B replied I would guess maintenance when they install it. Surveyor asked DON-B what she does if there is a gap between the mattress and foot board. DON-B replied I let maintenance know. Surveyor informed DON-B and Regional Director of Clinical Services-H of the approximate five-inch gap between R110 air mattress and foot board. Surveyor inquired if there is a mattress policy. On 6/2/26, at 10:38 a.m., DON-B informed Surveyor she put a spacer between R110's mattress and bedframe. On 6/2/26, at 11:22 a.m., Surveyor asked DON-B if there was a mattress policy. Regional Director of Clinical Services-H stated there is not explaining she has corporate looking for it. Surveyor was not provided with a mattress policy. 2.) Surveyor conducted a review of the facility's Misconduct Incident Report that was submitted to the State Survey Agency on 4/24/26. The report documents that on 4/17/26 at approximately 9:00 PM, R59 sustained a witness fall from bed while receiving cares from CNA (Certified Nursing Assistant)- E. At the time of the incident, R59's care plan identified R59 as requiring assist of one staff for cares and staff were following the current care plan. R59 sustained a fracture of lumbar spine. The incident summary documents that R59 was positioned on her/his right side facing the window. The bed positioned against the window wall. Staff reported the bed suddenly lifted on the window side, causing R59 to fall to the floor. Staff immediately called for assistance and 911 was contacted and R59 was transported out to the emergency department for further evaluation. The Investigation findings document that post-incident inspection identified a broken plastic clip securing (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the air mattress strap to the frame on R59's left side. The mattress was immediately removed from service and replaced. Corrective Actions documented all facility air mattresses were inspected for defects, securement clips and proper function. All beds were inspected for proper functionality. Any identified variances were corrected immediately. Maintenance system was updated to include preventative maintenance checks on air mattress tie-down clips and functionality. Incident investigation identified a failed mattress securing clip during equipment inspection. In addition, the facility's investigation included a signed statement from Maintenance Director- D, dated 4/19/26, documenting the Maintenance Department inspected all air mattress beds to ensure the plastic tie down clips were not cracked or broken and functioning as intended. The inspection of tie down clips was added to the Maintenance Department PM log under our Tells system. Surveyor did request to review the PM log in the Tells system and was not provided a log for inspection of tie down clips completed by the Maintenance Department. On 6/1/26 at 12:05 PM, Surveyor interviewed Director of Maintenance (DM)- D regarding routine maintenance of resident beds and mattresses. MD-D stated they do not have a log of routine maintenance checks on resident beds as they cannot physically check every bed. MD-D stated the maintenance department will put a new mattress in place, such as a specialty air mattress, when requested by nursing. DM-D stated the specialty air-mattress has 3 straps on each side that are clipped together around the bedframe. There would be a total of 6 straps holding the air mattress in place on the bed frame. Surveyor asked DM- D if he was aware R59's air mattress had a broken clip. DM- D stated he was not aware and if 1 clip was broken, the other clip/straps would still hold the mattress in place. DM-D stated he does not routinely check the beds and air mattress after they put them in place for resident use. DM-D stated the nursing staff are the eyes and ears and would notify the maintenance department if something was broken or not working properly. On 6/1/26 at 2:45 PM, Surveyor made observations of R59's room arrangement and bed/mattress while R59 was out of the room. R59's head of the bed was now against the wall with the window, and the left side of the bed was up against the wall. It was noted there was a bariatric mattress (48 inches wide) on a twin-size bedframe. Surveyor observed the mattress was hanging over the bedframe, on the left side, approximately 5 inches. The entire left side of the mattress was not supported by the bedframe and could easily be lifted up on the bedframe. The entire mattress was easily moved from the bed frame as it was not appropriately attached and too big for the bed frame itself, preventing it from fitting in the bed frame brackets. This made for an unsafe environment for R59 as the mattress could fall off the bedframe if R59 rolled to her left side. On 6/1/26 at 3:13PM, Surveyor interviewed DM-D and asked if he could confirm Surveyors observation regarding R59's mattress being too large for the frame. DM- E confirmed that after R59 fell from the bed on 4/17/26, the air mattress was replaced with a regular pressure reduction mattress. DM- D stated that the bedframe itself was not switched out. DM- D confirmed the mattress that was currently on R59's bed was a bariatric mattress that was 48 inches wide. DM- E confirmed the mattress must fit in between the bed frame brackets in order for it to be secure. During this observation, DM- E confirmed that no one in the maintenance department had been up to adjust the bedframe, although the bedframe had been adjusted after Surveyors observation at 2:45 PM on 6/1/26. The mattress was now positioned correctly as the bedframe itself had been widened. DM- D stated he does not regularly get into each resident's room and depends on staff to alert him if there is something not working properly. On 6/1/26 at 3:30 PM, Surveyor interviewed Nursing Home Administrator A and DON- B regarding (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyors observation of R59's mattress being too large for the bedframe with a 5-inch overhang. Administrator- A and DON- B stated they had not been in R59's room to observe the bedframe. At this time, Surveyor stated there were additional safety concerns for R59 and the bed was a continued accident hazard. Nursing Home Administrator- A was asked if the facility is conducting routine maintenance on resident beds. Nursing Home Administrator- A stated he would provide Surveyor with the Tells report that is used to log the resident bed checks completed by maintenance. As of the time of exit, the Tells report provided was a check for bed rail inspection. This inspection is conducted for 1 resident who uses a bed rail.