STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525406	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Omro	500 Grant Ave Omro, WI 54963

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 0689 Level of Harm - Minimal harm or potential for 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, staff interview, and record review, the facility did not ensure a fall intervention was in place and post-falls assessments were accurately completed for 3 residents (R) (R1, R2, and R3) of 3 sampled residents.R1 had multiple falls since admission. R1's care plan contained an intervention for 2 body pillows when in bed. The intervention was not consistently implemented. In addition, R1's post fall assessments were not completed per policy.R2 had a fall on 10/1/25. R2's post fall assessments were not completed per policy.R3 had a fall on 10/5/25. R3's post fall assessments were not completed per policy. Findings include: The facility's Fall Reduction Policy, revised 10/13/23, indicates: Risk Identification and Assessment: .4. Identified risk factors should be discussed in the Care Area Assessment (CAA) documentation via the Minimum Data Set (MDS) and addressed in the resident's care plan to assure individualized interventions to reduce the risk are implemented. The facility's Post Fall Policy, revised 10/13/23, indicates: After a fall, staff should document on the 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 .report any changes in function, increased pain, and changes in cognition for further evaluation. 1.On 10/21/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including dementia with severe psychotic disturbance, Alzheimer's disease, and anxiety. R1 was admitted to the facility due to a fall that occurred at home with a sacral fracture. R1's Minimum Data Set (MDS) assessment, dated 8/29/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severe cognitive impairment. R1 had a Guardian for healthcare decision making. A care plan, initiated 8/29/25, indicated R1 was at high risk for falls related to a closed fracture of the sacrum, severe dementia, and a history of falls and was unaware of R1's safety needs. The care plan contained an intervention, initiated 10/7/25 and revised10/8/25, for body pillow(s) in bed at night to use for comfort on each side of R1 when in bed. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/25 at 12:28 PM, Surveyor observed R1 in bed with one body pillow on the outside of R1's body. Surveyor noted a second body pillow was on a chair in the room. Surveyor interviewed Certified Nursing Assistant (CNA)-C who confirmed there was one body pillow in bed with R1. CNA-C stated CNA-C usually places a body pillow in between a resident's legs for comfort, but placed the pillow alongside R1 instead. When asked about the second body pillow on R1's chair, CNA-C indicated the pillow was used per staffs' discretion. When Surveyor showed CNA-C the care plan that indicated R1 should have 2 body pillows in bed, CNA-C stated CNA-C wasn't aware of the need for a second body pillow and didn't usually work on R1's wing. On 10/21/25, Surveyor reviewed post fall assessments for R1 and noted the following: ~ A post fall assessment, dated 9/20/25 at 12:55 AM, contained vital signs from 9/19/25 at 10:11 AM and a pain evaluation from 9/19/25 at 11:43 PM. ~ A post fall assessment, dated 9/20/25 at 11:53 AM, contained an oxygen saturation level from 9/19/25 at 10:11 AM. ~ A post fall assessment, dated 10/2/25 at 6:51 AM, contained vital signs from 9/29/25 at 1:28 PM. ~ A post fall assessment, dated 10/5/25 at 7:12 AM, contained vital signs from 10/5/25 at 12:10 PM. ~ A post fall assessment, dated 10/5/25 at 3:12 PM, contained vital signs from 10/5/25 at 12:10 PM and a pain assessment from 10/5/25 at 6:18 PM. ~ A post fall assessment, dated 10/6/25 at 1:02 AM, contained vital signs from 10/5/25 at 12:10 PM. ~ A post fall assessment, dated 10/6/25 at 5:58 AM, contained vital signs from 10/7/25 at 11:28 AM. ~ A post fall assessment, dated 10/6/25 at 9:18 AM, contained an oxygen saturation level from 10/5/25 at 12:10 PM. ~ A post fall assessment, dated 10/6/25 at 1:58 PM, contained vital signs from 10/7/25 at 11:28 AM. ~ A post fall assessment, dated 10/6/25 at 9:49 PM, contained a blood pressure and temperature from 10/6/25 at 3:32 PM, a pulse and oxygen saturation level from 10/6/25 at 5:40 PM, and a respiration rate from 10/6/25 at 9:19 AM. ~ A post fall assessment, dated 10/7/25 at 6:11 AM, contained vital signs from 10/7/25 at 11:28 AM. ~ A post fall assessment, dated 10/7/25 at 2:12 PM, contained vital signs from 10/7/25 at 11:28 AM ~ A post fall assessment, dated 10/7/25 at 5:34 PM, contained vital signs from 10/7/25 at 11:28 AM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A post fall assessment, dated 10/8/25 at 2:43 AM, contained vital signs from 10/7/25 at 11:28 AM. On 10/21/25 at 12:42 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff had most likely missed some of the assessments and completed them in batches with one set of vital signs which is why some of the assessments had vital signs that were taken in the future. DON-B also verified old vital signs were used in some of the assessments. DON-B verified staff should take a set of vital signs for each post fall assessment completed. DON-B also confirmed care plan interventions should be in place for R1. 2. On 10/21/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, asthma, obesity, depression, and hypertension. R2's most recent MDS assessment, dated 7/25/25, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. R2 was responsible for R2's healthcare decisions. R2's most recent comprehensive care plan indicated R2 was at high risk for falls. On 10/21/25, Surveyor reviewed post fall assessments completed for R2 and noted the following: ~ A post fall assessment, dated 10/2/25 at 1:04 AM, contained vital signs from 9/27/25 at 12:26 PM and a pain evaluation from 10/1/25 at 10:51 PM. ~ A post fall assessment, dated 10/2/25 at 9:06 AM, contained a temperature, respiration rate, and oxygen saturation level from 9/27/25 at 12:26 PM. ~ A post fall assessment, dated 10/2/25 at 10:35 PM, contained a temperature and oxygen saturation level from 9/27/25 at 12:26 PM, a blood pressure and pulse from 10/2/25 at 10:37 AM, and a respiration rate from 10/3/25 at 6:51 AM. ~ A post fall assessment, dated 10/3/25 at 8:36 AM, contained a temperature and oxygen saturation level from 9/27/25 at 12:26 PM, a blood pressure and pulse from 10/2/25 at 10:37 AM, and a respiration rate from 10/3/25 at 6:51 AM. ~ A post fall assessment, dated 10/3/25 at 10:05 PM, contained a temperature and oxygen saturation level from 9/27/25 at 12:26 PM, a blood pressure and pulse from 10/2/25 at 10:37 AM, and a respiration rate from 10/3/25 at 6:51 AM. (See interview under example #3). 3. On 10/21/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including stroke, vascular dementia, type 2 diabetes, depression, anxiety, and dysphagia. R3's most recent MDS assessment, dated 7/28/25, had a BIMS score of 5 out of 15 which indicated R3 had severe cognitive impairment. R3 had a Guardian. R3's most recent comprehensive care plan indicated R3 was at high risk for falls. On 10/21/25, Surveyor reviewed post fall assessments completed for R3 and noted the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A post fall assessment, dated 10/6/25 at 1:17 AM, contained a blood pressure, pulse, temperature, respiration rate, and oxygen saturation level from 10/5/25 at 2:20 PM. ~ A post fall assessment, dated 10/6/25 at 6:23 PM, contained a blood pressure, pulse, temperature, respiration rate, and oxygen saturation level from 10/6/25 at 10:23 AM and a pain evaluation from 10/7/25 at 3:56 PM. ~ A post fall assessment, dated 10/7/25 at 2:23 AM, contained a blood pressure, pulse, temperature, respiration rate, and oxygen saturation level from 10/6/25 at 10:23 AM and a pain evaluation from 10/7/25 at 3:56 PM. ~ A post fall assessment, dated 10/8/25 at 2:40 PM, contained vital signs from 10/7/25 at 6:47 PM. ~ A post fall assessment, dated 10/8/25 at 12:57 PM, contained a blood pressure, pulse, temperature, respiration rate, and oxygen saturation level from 10/725 at 6:47 PM and a pain evaluation from 10/8/25 at 8:13 AM. On 10/21/25 at 12:45 PM, Surveyor interviewed DON-B who verified older vital signs were used in the post fall assessments and a new set of vital signs should be obtained during each assessment to ensure adequate trending and post-fall monitoring.