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	04/01/2026

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 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, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 1 resident (R) (R1) of 4 sampled residents. R1 was on enhanced barrier precautions (EBP) due to a suprapubic catheter. On 4/1/26, staff did not wear gowns while providing personal care for R1. Findings include: The facility's Enhanced Barrier Precautions policy, dated 3/2024, indicates: It is the policy of this facility that EBP, in addition to standard and contact precautions, will be implemented during high-contact resident care activities when caring for residents who have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as residents with chronic wounds requiring a dressing, indwelling medical devices .High-contact resident care activities include: Dressing, bathing/showering . On 4/1/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including history of urinary tract infection (UTI), suprapubic catheter, and pressure injury. R1's Minimum Data Set (MDS) assessment, dated 1/21/26, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R1 had moderate cognitive impairment. R1 was responsible for R1's healthcare decisions. R1's medical record indicated R1 was hospitalized from [DATE] to 3/28/26 for a UTI, nose bleed, and suprapubic catheter dysfunction. R1 had a history of UTIs which resulted in the placement of a suprapubic catheter in November 2025. R1 had a diagnosis of paraplegia with lumbar and sacral spina bifida which placed R1 at high risk for pressure injuries. R1 was being treated for moisture-associated skin damage in the sacral/peri-area. R1 was on EBP related to the suprapubic catheter. On 4/1/26 at 10:00 AM, Surveyor observed Certified Nursing Assistant (CNA)-C and CNA-D bath and dress R1 without wearing gowns. On 4/1/26 at 10:20 AM, Surveyor interviewed CNA-C who indicated personal protective equipment (PPE) for EBP should be worn during high-contact resident cares. CNA-C verified CNA-C did not wear a gown while bathing and dressing R1. On 4/1/26 at 1:05 PM, Surveyor interviewed CNA-D who verified CNA-D did not wear a gown while bathing and dressing R1. On 4/1/26 at 12:26 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-E who indicated staff should wear a gown and gloves while bathing and grooming residents on EBP. On 4/1/26 at 1:09 PM, Surveyor interviewed Director of Nursing (DON)-B who verified staff should wear a gown and gloves while bathing and dressing residents on EBP.

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