STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525429	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Wisconsin Rapids	130 Strawberry LN Wisconsin Rapids, WI 54494

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and record review, the facility did not ensure a medication cart was locked when unattended and that medications were stored appropriately. This practice had the potential to affect more than 4 of the 51 residents residing in the facility. On 7/25/25, staff left a medication cart unlocked and unattended on multiple occasions. In addition, staff left medications on top of an unattended medication cart. Findings include:The facility's Administering Medications policy, revised 1/22/24, indicates: .Medication will remain secured in a locked cabinet/cart unless in direct view of the individual administering the medication. 1.On 7/25/25 at 8:28 AM, Surveyor observed Licensed Practical Nurse (LPN)-C prepare medication. LPN-C then walked down the 500 wing to ask a question and left the medication cart unlocked. Eight residents were in the vicinity of the cart at the time.On 7/25/25 at 8:34 AM, Surveyor interviewed LPN-C who confirmed the medication cart should have been locked when unattended. On 7/25/25 at 10:42 AM, Surveyor approached the nurses' station between the 500 and 600 wings and noted the 600 wing medication cart was pushed against the wall near the outside door. The cart was unlocked and unattended and out of LPN-C's view.On 7/25/25 at 10:42 AM, Surveyor interviewed LPN-C in the nurses' station who confirmed the medication cart should have been locked when unattended. Two residents were in the lobby at the time. 2. On 7/25/25 at 8:46 AM, Surveyor observed LPN-C prepare medications. LPN-C then walked down the 600 wing to administer the medications and left five medication cards and two bottles of medication unattended on top of the medication cart. On 7/25/25 at 8:57 AM, Surveyor observed Director or Nursing (DON)-B inform LPN-C that medications were left unattended on top of the medication cart. LPN-C returned to the cart and secured the medications.On 7/25/25 at 2:13 PM, Surveyor interviewed DON-B who confirmed medication carts should be locked when unattended and medications should not be left on top of an unattended medication cart.

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