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	05/20/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure assistance for activities of daily living (ADLs) was provided in a timely and consistent manner for 4 residents (R30, R13, R1, and R38) of 5 sampled residents. R30's call light was shut off prior to staff completing R30's request. Staff did not return in a timely manner to complete cares for R30. R1 stated staff typically take 30 minutes to respond to R1's call light. R13's call light was activated for 14 to 24 minutes before staff provided care. R1 (who lived across the hall) was interviewed and stated R13's call light was previously on for 60 minutes. R38 stated it can take 30 minutes for staff to respond to a call light. Staff verified residents may have to wait for their needs to be met. Findings include: Between 5/19/26 and 5/20/26, Surveyor reviewed the facility's Resident Council minutes. The April 2026 minutes indicated residents had concerns with long call light response times on weekends. Residents also had concerns with staff turning lights off without providing care and not returning to provide care. 1.On 5/19/26, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had a diagnosis of paraplegia. R30's Minimum Data Set (MDS) assessment, dated 4/10/26, stated R30 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS assessment indicated R30 was dependent on staff for toileting, showering, transfers, and lower body dressing and required partial to moderate assistance for upper body dressing. On 5/19/26 at 1:31 PM, Surveyor noted R30's call light was activated. On 5/19/26 at 1:39 PM, Surveyor observed Activity Director (AD)-C enter and exit R30's room. R30's call light was no longer on. On 5/19/26 at 1:41 PM, Surveyor asked R30 if R30's needs were met prior to AD-C exiting the room. R30 stated AD-C said the Certified Nursing Assistants (CNAs) were busy and would be in after they finished assisting another resident. R30 verified AD-C turned off R30's call light. R30 stated R30 wanted to get up for the day because R30 had a visitor coming. On 5/19/26 at 2:00 PM, Surveyor entered R30's room to see if staff had been in to provide care. R30 was still in bed and stated staff must have forgotten again. R30 indicated it occurred more frequently in the last 2 weeks and R30 was sick of it. R30 indicated R30 needed assistance with transferring and getting ready and was concerned R30 would not be ready when R30's family arrived. Surveyor observed a bell on R30's window. R30 indicated R30 could use the bell in case staff did not respond timely. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/26 at 2:09 PM, Surveyor exited R30's room and observed multiple CNAs at the nursing station for shift change. At 2:11 PM, Surveyor observed staff enter R30s room. On 5/19/26 at 3:03 PM, Surveyor interviewed AD-C who verified R30 wanted to get up for the day but staff were busy. AD-C indicated a CNA (AD-C could not recall which one) told AD-C to turn R30's call light off. Surveyor informed AD-C that staff did not return timely to meet R30's needs. (See interview under example 3.) 2. On 5/19/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. R13's MDS assessment, dated 4/23/26, stated R13 had a BIMS score of 15 out of 15, indicating intact cognition. The MDS assessment indicated R13 was either dependent or required substantial staff assistance for most ADLs, including toileting, bathing, and personal hygiene. On 5/19/26 between 1:00 PM and 1:10 PM, Surveyor interviewed R1 who lived across the hall from R13. Surveyor noted some time between 1:00 and 1:10 PM, R13's call light was activated as indicated by the light above R13's room. As Surveyor exited R1's room, R13 was sitting in a wheelchair in the door of R13's room. Surveyor continued to observe R13's call light. At 1:23 PM, Surveyor interviewed R13 who stated R13 activated the call light approximately 20 minutes ago. R13 stated R13 needed R13's brief changed before therapy. At 1:24 PM, two staff answered R13's call light and provided assistance. R13's call light was on between 14 and 24 minutes. On 5/19/26 at 11:17 AM, Surveyor interviewed R1 who stated call lights are typically answered in 30 minutes, although some staff answer sooner. R1 stated R13's call light had been on previously for approximately 60 minutes. (R1's MDS assessment, dated 3/23/26, stated R1 had a BIMS score of 15 out of 15, indicating intact cognition.) (See interview under example 3.) 3. On 5/19/26, Surveyor reviewed R38's medical record. R38 was admitted to the facility on [DATE] and had diagnoses including stroke and fall with fracture. R38's MDS assessment, dated 5/4/26, stated R38 had a BIMS score of 11 out of 15, indicating moderately impaired cognition. The MDS assessment indicated R38 was either dependent or required substantial assistance of staff for most ADLs, including toileting, bathing, and personal hygiene. On 5/19/26 at 10:11 AM, Surveyor interviewed R38 who indicated staff can take up to 30 minutes to answer R38's call light. On 5/19/26 at 1:46 PM, Surveyor interviewed CNA-D who indicated CNA-D tries to answer call lights within 10 to 20 minutes which is not always possible. CNA-D indicated there are 2 CNAs and a float for the unit and residents have to wait at times when 2 staff are required for a transfer. CNA-D indicated the call light system does not indicate who is waiting the longest. CNA-D stated staff might exit a room and see multiple call lights on. CNA-D indicated staff prioritize call lights through knowledge of the residents and their schedules. On 5/19/26 at 4:36 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility does not tell staff to meet residents' needs in a certain amount of time, just that it be timely. DON-B confirmed staff should not turn a call light off prior to meeting a resident's needs.

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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 observation, staff and resident interview, and record review, the facility did not provide wound care as ordered for 1 resident (R) (R4) of 1 sampled resident. R4 developed a skin tear over a recently healed left posterior thigh wound. Physician orders were not transcribed in R4's medical record to continue treatment to protect the wound. R4's medical record did not indicate the wound was treated or covered as ordered between 5/8/26 and 5/15/26. Findings include: Between 5/19/26 and 5/20/26, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including chronic venous hypertension with ulcer and inflammation of left lower extremity and peripheral vascular disease (PVD). R4's most recent Minimum Data Set (MDS) assessment, dated 4/17/26, stated R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.R4's medical record contained the following orders: ~ Left posterior thigh: Cleanse with soap and water. Apply petroleum gauze over wound, cover with 4x4 Allevyn (absorbent foam dressing). Change dressing every 3 days (ordered 4/30/26 at 5:44 PM; discontinued 5/8/26 at 12:57 AM)~ Check on wound dressings every shift to ensure dressings are in place. Replace dressings as needed if dressing missing or not adhered every shift for excoriated area on posterior upper left leg (ordered 5/15/26 at 11:02 PM; discontinued 5/19/26 at 8:06 AM)~ Cleanse area to posterior left thigh with soap and water. Apply petroleum gauze to wound bed. Cover with 4x4 border foam one time only until 5/19/26 at 11:59 PM (ordered 5/19/26 at 5:08 PM)~ Cleanse area to posterior left thigh with soap and water. Apply petroleum gauze to wound bed. Cover with 4x4 border foam one time a day every 3 days (ordered 5/19/26 at 5:08 PM) A note by Director of Nursing (DON)-B, dated 5/5/26, indicated: . will continue wound orders until new orders received. On 5/7/26, R4 was seen by the wound clinic. Documentation indicated the wound was healed. The wound clinic provided a treatment order to continue care for the healed wound site. R4's next wound clinic appointment was scheduled for 5/21/26. (Of note: The wound care order above was discontinued on 5/8/26 at 12:57 AM by LPN-G.)A progress note, dated 5/15/26 and written by LPN-I, indicated LPN-I notified the provider the wound had opened and R4 had a skin tear on the left posterior thigh. (Of note: R4's medical record did not contain documentation to indicate R4's left posterior thigh wound was treated or covered between 5/8/26 and 5/15/26.)On 5/19/26 at 3:41 PM, Surveyor interviewed R4 who stated R4 had an upcoming wound clinic appointment on 5/21/26 which should be R4's last appointment. R4 stated there was a wound on the back of R4's left leg. On 5/19/26 at 3:56 PM, Surveyor interviewed DON-B who stated R4 had skin issues on the right and left posterior thighs upon admission. DON-B stated R4's left posterior thigh wound was healed as of 5/5/26 and was R4's last open wound. When asked if R4 had any current open wounds, DON-B stated R4's wounds were healed. DON-B stated there was documentation of excoriation on R4's left posterior thigh on 5/15/26. DON-B stated R4's medical record contained a note written by LPN-I that indicated R4's provider was notified via the online messaging system. The provider responsed, May have above treatment order. The order to check wound dressings every shift to ensure dressings are in place and replace dressings as needed if missing or not adhered for excoriated area on the posterior upper left leg was transcribed on 5/15/26 at 10:02 PM by LPN-I. The order was discontinued on 5/19/26 at 8:06 AM by DON-B because DON-B thought the wound was healed. On 5/19/26 at 4:03 PM, Surveyor, DON-B, and Wound Nurse (WN)-H viewed R4's left posterior thigh. DON-B removed a foam border dressing that was dated 5/15 and initialed by of LPN-I. DON-B described R4's left posterior thigh and dressing while Surveyor observed: the dressing contained dried, yellow serous drainage; the skin tear was on the healed scar tissue and appeared superficial; the surrounding skin contained slight excoriation and did not show signs of infection. On 5/19/26 at 4:40 PM, Surveyor interviewed DON-B who stated the confusion with R4's wound care order was an oversight on DON-B and the nurse's part. DON-B stated DON-B discontinued the wound treatment that was entered on 5/15/26 because DON-B thought R4's wound was healed. (continued on next page)

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