STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525484	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Appleton North	2915 N Meade St Appleton, WI 54911

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure pressure injury wound care was provided for 1 resident (R) (R1) of 2 sampled residents.R1 had a deep tissue injury on the right heel and a wound care order for daily dressing changes. R1's wound care order was not consistently followed.Findings include:The facility's Procedure Clean Dressing Change policy, dated 2/24/23, indicates: .1. Verify physician's order for the procedure/treatment. 2. Review the resident's care plan, current orders, and diagnoses as applicable to determine if there are special resident needs .16. Date and initial wound dressing when applied .Medical record documentation and follow-up as applicable: 1. The date and time the dressing was changed. On 9/2/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including sepsis, cellulitis of right lower limb, non-pressure chronic ulcer of other part of right lower leg with fat layer exposed, and abrasion of left elbow. R1's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderately impaired cognition. R1 had an activated Power of Attorney for Healthcare (POAHC). R1's medical record contained the following orders:~ Treatment - Right Heel - Betadine daily and as needed (PRN) every day shift for wound care (start date 11/26/24).~ Treatment - Right Heel - Clean with wound cleanser, pat dry, apply Santyl to wound bed, apply Telfa, wrap in Kerlix daily and PRN every day shift for wound care (start date 12/3/24).R1's December 2024 Treatment Administration Record (TAR) indicated R1's dressing change was not completed on 12/4/24.A Nurse Practitioner (NP) note, dated 12/10/24, indicated R1 had what appeared to be a deep tissue injury (DTI) on the right heel that measured 1.5 centimeters (cm) x 3. 5 cm x 0.1 cm. The surface area measured 5.25 square centimeters (cm2) with 80% eschar and 20% slough. There was light serous exudate, no induration, and the edges appeared cliff-like. The peri-wound was normal in temperature and color. The note indicated the wound deteriorated overall due to nutritional compromise. R1 was started on Prostat, vitamin C, and a multivitamin. On 9/2/25 at 3:01 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R1's dressing change was not completed on 12/4/24 and confirmed R1's DTI dressing should be changed daily. DON-B stated DON-B expects staff to follow orders for daily wound care and indicated R1's wound care should be completed daily and documented.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525484	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Appleton North	2915 N Meade St Appleton, WI 54911

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(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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525484	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Appleton North	2915 N Meade St Appleton, WI 54911

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure appropriate fall interventions were in place for 2 residents (R) (R1 and R4) of 2 sampled residents. R1's falls care plan was not updated with an intervention after a fall on 12/12/24.R4's falls care plan contained an intervention for a urinal at bedside following a fall on 8/12/25. The intervention was not consistently followed.Findings include:The facility's Post Fall Policy, revised 10/13/23, indicates: .Notification and Communication: Communicate with staff on unit that a fall has occurred and intervention put in place to reduce risk of another fall. Documentation: Immediate intervention put in place.On 9/2/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including cellulitis of right lower limb, non-pressure chronic ulcer of right lower leg, dysphagia, adjustment disorder with anxiety, macular degeneration, hypertension, insomnia, and overactive bladder. R1's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC). R1 discharged to the hospital on [DATE] due to a change in condition and did not return to the facility. R1's falls care plan, revised 11/19/24, indicated R1 was at moderate risk for falls related to impaired physical mobility, self-care deficit, activity intolerance, fatigue, generalized weakness, decreased muscle strength, incontinence, and a history of mood disorder. The care plan also indicated R1 received antidepressant medication. Following a fall on 11/25/24, an intervention was added for a Dycem (an anti-slip pad) under R1's recliner cushion.A progress note, dated 12/12/24 at 10:02 AM, indicated R1 fell at approximately 7:30 AM and was on aspirin and Eliquis (a blood thinning medication). R1 was not sure if R1 hit R1's head. A nurse completed an assessment, including vital signs and neuro checks. R1 reported buttocks pain at a level 4 out of 10 and had a skin tear on the left elbow. The Nurse Practitioner (NP) responded. A progress note, dated 12/12/24 at 12:15 PM, indicated staff should complete post fall monitoring and fall precautions per the facility's protocol and monitor for any bruising or bleeding due to anticoagulation/antiplatelet use. Staff should also monitor and update with any new or worsening symptoms or further concerns and update physician services with follow-up vital signs. The NP agreed with bordered foam for skin tear treatment and indicated to implement orders as stated. A risk management report for R1's fall on 12/12/24 indicated: Certified Nursing Assistant (CNA) informed writer that R1 was found on the floor at 7:30 AM with R1's head toward the dresser. and wearing Prevalon boots (used to reduce pressure on the heels and help prevent pressure injuries). R1 was incontinent of bowel and bladder. It was unknown if R1 hit R1's head. Neuro checks were within normal limits. R1's pulse was 118. R1 reported buttocks pain and had a skin tear on the left elbow. Notifications were completed and R1 was transferred via Hoyer lift into bed. The report indicated the Interdisciplinary Team (IDT) reviewed the incident on 12/22/24 and concluded that R1 attempted to self-transfer while wearing Prevalon boots which caused the fall. An intervention was added to float heels when in bed and wear boots when in wheelchair or recliner. R1's care plan was reviewed and updated. On 9/2/25 at 1:28 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility's process was to add an immediate intervention following a fall. NHA-A checked R1's medical record and indicated NHA-A could not find an immediate intervention that was added to R1's care plan. 2. On 9/2/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including hypoxic ischemic encephalopathy, peripheral vascular disease (PVD), insomnia, and anoxic brain damage. R4's MDS assessment, dated 8/27/25, had a BIMS score of 0 out of 15 which indicated R4 had severe cognitive impairment.R4's falls care plan, revised 8/20/25, indicated R4 was at high risk for falls related to anoxic encephalopathy, impaired physical mobility, self-care deficit, fatigue, generalized weakness, cognitive impairment, decreased cardiac function, and hearing deficit. The care plan also indicated R4 received antipsychotic and diuretic medication. R4 was noted to remove gripper socks and attempted to self-transfer due to impaired cognition and was observed self-transferring alone without notifying staff of R4's needs. The care plan contained an intervention to have a urinal at R4's bedside which was initiated after a fall on 8/12/25. On 9/2/25 at 2:15 PM, Surveyor observed R4 in bed without a urinal at R4's bedside. On 9/2/25 at 2:30 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who confirmed R4 did not have a urinal at the bedside. LPN-C checked R4's bathroom and did not see a urinal there either. On 9/2/25 at 4:30 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed fall interventions should be in place for residents, however, DON-B needed to review R4's care plan and was unsure if R4