| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525484 | A. Building<br>B. Wing | 03/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Edenbrook of Appleton North | 2915 N Meade St<br>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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure adequate supervision was provided for 1 resident (R) (R1) of 3 sampled residents at risk for wandering/elopement.R1 had a hsitory of elopement and WanderGuard (WG) removal (a device placed on a person to alert facility staff if the person is exiting an area unsupervised). Despite the fact that R1 removed the WG multipe times and exited the facility unsupervised, the facility failed to implement increased supervision for R1 or increased monitoring for WG placement. On 11/17/26 at approximately 10:00 PM, staff discovered R1 was not in the facility during rounds. R1 was last seen by staff in the dining room at approximately 9:45 PM. Staff searched the facility and surrounding area and located R1 in the bathroom of a local business one block away. Staff assisted R1 back to the facility and noted R1's WG had been removed. R1's medical record indicated R1 attempted to elope from the facility on 10/23/25, 11/2/25, 11/6/25, 11/10/25, and 11/13/25 and had removed R1's WG on 11/6/25, 11/10/25, and 11/13/25. The facility did not increase supervision for R1 or increase the frequency of WG checks for placement and function. Staff did not consistently implement other interventions related to wandering such as offering to take R1 outside or engage in specific activities. In addition, staff did not consistently check the placement and functioning of R1's WG, determine if the WG was in place, or determine how R1 continued to remove the WG.The facility's failure to provide adequate supervision for a resident at risk for elopement created a finding of immediate jeopardy that began on 11/6/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 3/3/26 at 12:50 PM. The immediate jeopardy was removed on 3/3/26, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include:The facility's Elopement Risk and Prevention policy, revised 6/2/22, indicates: All residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues identified in their individual care plan .The resident's arm/leg monitor bracelet (WanderGuard) will be checked every shift for placement and daily to ensure the device is functioning properly .Residents identified as at risk for elopement will have interventions put in place .In the instance that a resident walks away from the facility and cannot be located by staff, all staff are responsible to assist with searching every room and bathroom .During the initial 15-30 minutes, cover a radius of approximately 1 mile from the facility, interview staff, and determine who last saw the resident and what they were wearing.On 3/2/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including dementia, seizure disorder, schizoaffective disorder, and bipolar disorder. R1's most recent Minimum Data Set (MDS) assessment, dated 12/3/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition. R1 had a Guardian upon admission. R1 discharged to another skilled nursing facility on 12/17/25.R1's medical record contained a protective placement document that was registered with the local courthouse on 8/20/25. The document stated R1 required placement on a secured unit due to previous absconding attempts and indicated safety could not be<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | assured on an unsecured unit. R1's comprehensive care plan, initiated 5/7/25, stated R1 was an elopement risk/wander risk and continued to leave the facility without notice/unauthorized. Initial interventions included: Monitor for/document episodes of wandering and triggers; Wander risk assessment per policy; WanderGuard (WG) placement; Add to elopement risk binder/list; Identify pattern of wandering; and Discuss expectations of signing out before leaving (otherwise privileges may be restricted to supervised). An initial Elopement Risk Assessment, dated 5/5/25, indicated R1 was at low risk for elopement.A nursing note, dated 5/7/25 at 1:41 PM, indicated a WG was applied after R1 attempted to call friends/others to take R1 home. The note indicated R1 kept asking to go home to get things. R1's Guardian did not want R1 to leave the facility except for appointments because he did not think R1 would return to the facility. A WG was applied to R1's left wrist. A significant change Elopement Risk Assessment, dated 5/7/25, indicated R1 was at risk for elopement.A care conference note, dated 8/13/25 at 2:31 PM, indicated R1 was not permitted to go outside the facility alone.On 8/27/25, there was an added focus to R1's elopement care plan that indicated R1 historically cut off the WG. (Despite the fact the facility knew R1 had a history of cutting off the WG, there was no additional supervision or increased checks to ensure R1's WG was in place.)A quarterly Elopement Risk Assessment, dated 8/29/25, indicated R1 was at high risk for elopement.A psychiatric visit note, dated 9/2/25, indicated R1's Fanapt (an antipsychotic medication used to treat schizophrenia-type disorders) was stopped while R1 was hospitalized . R1 did not agree to restart the medication despite encouragement. The note indicated R1 had delusional thinking about staff and lacked insight into R1's role in ongoing problems at the facility.A behavior note, dated 10/23/25 at 2:23 PM, indicated R1 was in the guest restroom for over an hour with R1's wheelchair and personal belongings and refused to talk to staff. A behavior note, dated 10/23/25 at 3:19 PM, indicated R1 walked up and down the hallways wearing a coat. R1's clothing and belongings were piled on R1's wheelchair. A behavior note, dated 10/23/25 at 7:30 PM, indicated RN-F observed R1 in the dining room. Several minutes later, RN-F attempted to ask R1 about dinner but could not find R1. A code was called. Staf found R1 hiding behind the therapy door in the courtyard (fully enclosed). R1 was asked to come back inside due to cold weather. R1 made nonsensical comments to staff.A behavior note, dated 11/2/25 at 12:07 PM, indicated R1 exited the facility and was in front of the building. R1 stated a friend was on the way to help pack R1's belongings for another facility. Staff attempted twice to have R1 wait inside and offered to call the friend, however, R1 remained outside. A Certified Nursing Assistant (CNA) watched R1 through the window and was instructed to inform RN-I if R1 moved away.A nursing note, dated 11/3/25 at 9:04 AM, indicated a new WG was applied to R1's right wristA nursing note, dated 11/4/25 at 12:10 PM, indicated R1 had an appointment with a psych provider. Despite multiple attempts to get R1 to go, R1 refused. R1 stated R1 did not believe staff, staff lied about R1's ride, and R1 had never seen a psych provider. R1's wheelchair was stacked with R1's belongings.A behavior note, dated 11/6/25 at 6:48 PM, indicated R1 cut off the WG and walked to the parking lot from the main entrance before RN-F brought R1 back inside. R1 stated the WG fell off and did not state where R1 was going. R1 was not wearing a coat and was pushing a wheelchair full of belongings. A new WG was applied to R1's right wrist.On 3/3/26 at 10:57 AM, Surveyor interviewed RN-F regarding R1's elopements and WG removals. RN-F verified RN-F worked when R1 exited the facility on 10/23/25 and 11/6/25. On 10/23/25, RN-F noted that R1 had been missing for a few minutes and was found hiding behind the door to therapy in the enclosed courtyard. RN-F stated R1's WG was in place at that time. RN-F stated an alarm did not sound because the door did not have a WG alarm. RN-F stated R1 walked out to the parking lot from the main entrance on 11/6/25 and RN-F brought R1 back inside. R1 did not state where R1 was going and said the WG fell off. R1 was not wearing a coat and was pushing a wheelchair full of belongings. A new WG was applied. When asked how R1 removed the WG, RN-F thought R1 obtained scissors from the reception desk. A behavior note, dated 11/10/25 at 4:27 PM, indicated R1 cut off the WG and was outside near the front parking lot to get fresh air. The weather was below 30 degrees and R1 was not dressed appropriately. R1 was (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | encouraged to tell staff when R1 wanted to go outside. RN-J redirected R1 to go inside. A new WG was applied to R1's right wrist.(This was the second tine R1 cut of the WG in a matter of days. Despite the fact that R1 cut of the WG, there was no evidence the faciity addressed how R1 was cutting off the WG or that the facility increased supervision to prevent R1 from exiting the facility.)Interventions added to R1's elopement care plan on 11/11/25 included: Engage R1 in conversations about religion, flowers, or engage in rock painting/craft activities; Offer to go outside with staff and ensure adequate dress for the weather; Offer to assist with calling brother to obtain needed items or to remind of upcoming appointments; WG placed under wheelchair as R1 does not go anywhere without wheelchair but is known to remove WG on person. NHA-A also added triggers for elopement (scheduled appointments, needing items, wanting to go outside to pray) and de-escalation techniques (reminding R1 of scheduled transportation, offering to assist R1 with obtaining items, and offering to go outside) to R1's care plan at that time. (Although the facility placed a WG on R1's wheelchair, it should be noted manufacturer's recommendations discourage the placement of a WG near metal as it can interfere with radio frequency and decrease the capability of the WG's function.)A behavior note, dated 11/13/25 at 9:54 PM, indicated at approximately 6:40 PM, RN-H noted R1 left the facility through the front door without a walker or wheelchair. The WG alarm did not sound. R1 attempted to get into a visitor's vehicle and wanted a ride to [NAME] Bay. A CNA assisted R1 back inside. R1's WG had been cut off and was found on the 100 unit. A new WG was applied to R1's right wrist. An added focus was added to R1's elopement care plan to monitor for tailgating behaviors. On 3/4/26 at 2:13 PM, Surveyor interviewed RN-H regarding R1's elopements and WG removals. RN-H verified RN-H worked on 11/13/25 when R1 exited the facility and attempted to get into a visitor's vehicle. RN-H stated a visitor approached RN-H and stated a resident was attempting to get a ride with them. RN-H saw R1 exit the front door without a wheelchair or walker. RN-H escorted R1 back inside and noted R1's WG was missing. RN-H put a new WG on R1. RN-H did not recall ever offering to take R1 outside or engage R1 in discussions about religion or rock painting/crafts.A nursing note, dated 11/17/25 at 9:30 PM, indicated RN-C checked on R1 who stated R1 would come back to the 300 unit. A nursing note at 11:00 PM indicated R1 was nowhere to be found. A CNA stated they saw someone outside a local store one block away. RN-C went to the store and found R1 in the bathroom. R1 stated someone dropped R1 off there. RN-C and R1 walked back to the facility. A nursing note at 11:20 PM indicated R1 cut off the WG and staff were looking for a new one.On 11/17/25, an intervention was added to R1's elopement care plan to check daily if R1 needs items from outside the facility and assist with obtaining the items.Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency regarding the elopement on 11/17/25. The initial report stated staff discovered R1 was not in the facility during routine rounds on 11/17/25 approximately 10:00 PM. R1 had been seen less than 15 minutes prior. Staff searched the facility and the perimeter and located R1 outside a store across the street within 10 minutes. The investigation included a statement by RN-C that stated at approximately 7:00 PM, R1 was in the 100 unit dining room and received medication. At approximately 9:45 PM, RN-C was in the dining room again when R1 stated R1 would come back to the unit shortly for bed. During routine rounds and report with the night (NOC) shift at approximately 10:00 PM, RN-C could not locate R1. A code was called and staff searched the building. A NOC shift CNA reported that they saw a bag lady across the street at a store. RN-C searched the store, found R1 in the bathroom, and walked R1 back to the facility. R1 refused a skin assessment and anxiety medication. The facility's door did not alarm because R1 had cut off R1's WG and hid it in the front lobby. The facility's investigation did not contain any other staff interviews or statements. Staff were provided education on 11/17/25 on the facility's Elopement and Leave of Absence policies. Surveyor noted that the education did not include specific information related to R1 such as behaviors, personalized elopement interventions, and/or R1's continued removal of the WG. In addition, the investigation included a document titled Elopement Past Non-Compliance (PNC) that stated the facility identified that they could have potentially failed to keep R1 safe as R1 had cut off<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | the WG. Surveyor reviewed a map of the area and noted R1 was found at a store approximately 0.1 miles from the facility. The temperature was approximately 35 degrees, and it was dark. While it is unknown which route R1 took to the store, the store is located on a busy street. An Elopement Risk Assessment, dated 11/17/25, indicated R1 was at high risk for elopement. A nursing note, dated 11/18/25 at 3:01 AM, indicated PM staff reported R1's wheelchair was missing after R1 left the facility. R1's wheelchair was later found in the front guest restroom stacked with R1's belongings. Staff found R1's WG in a drawer in R1's room and reapplied the WG to R1's left wrist.R1's Treatment Administration Record (TAR) contained an order to check R1's right wrist for WG placement and function once per shift. The order was not updated to reflect that R1's WG was applied on 11/18/25. A nursing note, dated 11/20/25 at 1:10 AM, indicated R1 was no longer wearing the WG that was on R1's left wrist at the start of the shift. R1 stated R1 scratched at the WG and it fell off. Staff could not find the WG. Frequent checks were in place. A nursing note at 3:29 AM indicated staff observed R1 attempt to exit the building at 2:46 AM with a coat, a cane, and a purse. R1 stated R1 was going outside for fresh air and had chest pain. R1 was sent to the hospital for evaluation. An Elopement Risk Assessment, dated 12/2/25, indicated R1 was at risk for elopement. A psychiatric visit note, dated 12/4/25, inidicated R1 was hospitalized several times since September (2025). The note indicated R1 had poor judgement and insight based on recent behavior and was not overtly manic or psychotic, however, the provider was worried. The note also indicated R1 struggled with lack of insight into R1's current presentation which affected R1's physical and mental health.R1's TAR contained an order to check R1's right wrist for WG placement and function once per shift. There was no documentation for WG checks on the following dates/shifts: 10/21/25 PM shift, 11/5/25 PM shift, 11/7/25 AM shift, 11/19/25 PM shift, 11/28/25 NOC shift, 11/29/25 AM, PM, and NOC shifts, 11/30/25 AM, PM, and NOC shifts, 12/1/25 AM, PM, and NOC shifts, 12/2/25 AM, PM, and NOC shifts, 12/3/25 AM, PM, and NOC shifts, 12/4/25 AM, PM, and NOC shifts, and 12/4/25 AM, PM, and NOC shifts. Surveyor noted the order was discontinued on 11/26/25 after R1 went to the hospital and was not restarted until 12/5/25. R1's hospital record indicated R1 returned to the facility on [DATE] which meant there were no documented WG checks for 6 days after R1 returned to the facility.A nursing note, dated 12/16/25 at 5:29 PM, indicated staff observed R1 going through the receptionist's desk and puttting things in R1's pocket. R1 denied taking anything from the desk. On 3/2/26 at 1:12 PM, Surveyor interviewed NHA-A and Director of Nursing (DON)-B regarding R1's elopement attempts and safety interventions. NHA-A stated the facility did not attempt to increase supervision at regular intervals or increase checks for R1's WG despite multiple elopement attempts and WG removals. NHA-A and DON-B stated increased supervision and WG checks would increase R1's paranoia/delusions and increase R1's elopement attempts. NHA-A verified there was no documentation related to frequent/increased checks for R1. NHA-A also verified no new interventions related to wandering/elopement were added to R1's care plan after the 11/6/25 and 11/13/25 elopements because the Interdisciplinary Team (IDT) felt the current interventions were appropriate. On 3/3/26 at 11:25 AM, Surveyor interviewed CNA-G regarding R1's elopements and WG removals. CNA-G did not recall specific elopement attempts but indicated R1 locked R1's self in the bathroom, carried R1's belongings around the facility in a wheelchair, and removed R1's WG. CNA-G did not recall ever offering to take R1 outside, do crafts, or talk about religion. CNA-G was not sure how R1 removed the WG but thought R1 bit or chewed it off.On 3/4/26, Surveyor reviewed additional information provided by the facility, including a statement from RN-I regarding R1's elopement on 11/2/25. The statement indicated R1 went outside on R1's own and was not redirectable. Staff notified police who were also unable to redirect R1 back inside. Surveyor also reviewed a statement from RN-J regarding R1's elopement on 11/10/25. The statement indicated RN-J followed R1 outside to the front parking lot as R1 was observed cutting the WG off prior to going outside. R1 was redirected back into the facility and a new WG was applied. R1 stated R1 wanted to get fresh air. RN-J reminded R1 not to leave the building without staff. The failure to provide adequate supervision<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | for a resident with a history of elopement and WG removal created a reasonable likelihood for serious harm and led to the finding of immediate jeopardy. The facility removed the jeopardy on 3/3/26, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement the following action plan:Reviewed and revised care plans for all residents who display exit seeking behavior and/or scored at risk on their Elopement Risk Assessment.Reviewed the facility's Elopement Risk and Prevention policy and procedure to ensure it meets current standards of practice.Educated staff on the following: Ensuring each resident receives adequate supervision and assistive devices to prevent accidents; the facility's Elopement Risk and Prevention policy; How to properly respond and interventions to put in place if a resident exit seeks, leaves the facility, removes a WG, or searches for/is provided tools to remove a WG.Implemented weekly, bi-weekly, and monthly elopement audits and elopement drills.Reviewed and updated the Facility Assessment. |