| 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 | 06/17/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not appropriately notify a physician after a change of condition for 1 resident (R) (R6) of 3 sampled residents.Registered Nurse (RN)-C administered three doses of nitroglycerine (a fast-acting medication used to relieve/prevent chest pain) to R6. RN-C notified the physician via fax instead of the on-call service. Findings include: The facility's Policy and Procedure Change in Condition, revised 11/13/24, indicates: Purpose: To ensure prompt notification of the resident, the attending physician .of changes in the resident's physical, psychosocial, and/or mental condition and/or status .2. Specific information that requires prompt notification includes, but is not limited to .Instructions to notify the physician of changes in the resident's condition .R6 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure, atherosclerotic heart disease of native coronary artery with other forms of angina pectoris, and anxiety. On 6/17/26, Surveyor reviewed R6's medical record which included an order for nitroglycerine sublingual tablet 0.4 milligrams (mg) give 1 tablet sublingually as needed for chest pain 2 tabs under the tongue every 5 minutes, maximum 3 doses (take full set of vitals before and after dosage and update MD) (start date: 6/9/25).R6's Medication Administration Record (MAR) indicated R6 received nitroglycerine on 3/19/26 at 11:35 PM and 11:50 PM and on 3/20/26 at 12:01 AM. All doses were administered by Registered Nurse (RN)-C.A progress note written by RN-C on 3/20/26 at 4:46 AM included the nitroglycerine administration, a summary of the night shift from 3/19/26 into 3/20/26, and indicated the physician was updated. (Of note: The method used to update the physician was not mentioned in the progress note.) On 6/17/26 at 12:00 PM, Surveyor interviewed RN-C who stated nurses have to notify the physician after administering three doses of nitroglycerine. RN-C indicated they faxed the physician and wrote a progress note. On 6/17/26 at 4:18 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed nurses should notify the physician after administering the third dose of nitroglycerine as stated in the physician order. DON-B indicated nurses should notify the physician via the on-call service, not via fax. |

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 |
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