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	08/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect all 68 residents residing in the facility. The facility did not monitor and document food cooling temperatures. The walk-in cooler and dry storage area contained multiple undated and unlabeled items. The facility did not test Quaternary sanitizing solution used to sanitize food preparation areas in accordance with the manufacturer's instructions. The facility did not monitor warewashing temperatures to ensure minimum surface temperatures were achieved to prevent the spread of foodborne illness.Findings incude:Food Cooling:The 2022 Federal Food and Drug Administration (FDA) Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celsius (C) (135 Fahrenheit) (F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less.The 2022 FDA Food Code documents at section 3-501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods.During an initial kitchen tour that began on 8/4/25 at 8:09 AM, Surveyor observed the following pre-cooked and cooled foods in the walk-in cooler:~ An unlabeled plastic container that appeared to contain cooked ground meat (dated 8/2/25)~ An unlabeled steam table container that contained a red sauce (dated 7/3/25)~ An undated steam table container labeled for puree that contained what appeared to be roast beef~ Three steam table containers labeled puree fish (dated 7/18/25)~ Three steam table containers labeled puree peas (dated 7/29/25) ~ Three steam table containers labeled puree turkey dated 7/29/25~ Two covered and undated steam table containers labeled taco meat for Tuesday Surveyor also observed five uncovered steam table containers on a cart. Surveyor interviewed [NAME] (CK)-I who indicated CK-I left the containers out to cool before CK-I obtained temperatures and put the items in the walk-in cooler for future resident consumption. CK-I confirmed CK-I leaves food on the counter or a rolling cart to cool prior to putting it in the walk-in cooler and confirmed the containers were removed from the steam table after breakfast on 8/4/25. Surveyor and CK-I confirmed the following:~ Two containers of Cream of Wheat~ One container each of oatmeal, scrambled eggs, and sausage crumblesDuring a continuous kitchen observation that began on 8/5/25 at 10:54 AM, Surveyor toured the walk-in cooler with Dietary Manager (DM)-H who confirmed the following items in the cooler were pre-cooked, cooled, and stored for future resident consumption:~ An unlabeled plastic container with what appeared to be cooked ground meat (dated 8/2/25)~ An unlabeled steam table container that contained a red sauce (dated 7/3/25)~ An undated steam table container labeled for puree that contained what appeared to be roast beef ~ Three steam table containers labeled puree fish (dated 7/18/25)~ Three steam table containers labeled puree peas (dated 7/29/25) ~ Three steam table containers labeled puree turkey (dated 7/29/25)~ Two covered (continued on next page)

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and undated steam table containers labeled taco meat for TuesdaySurveyor did not observe the containers of Cream of Wheat, oatmeal, scrambled eggs, and sausage crumbles listed above in the walk-in cooler on 8/5/25. DM-H indicated the items were served for breakfast on 8/5/25. CK-I indicated the items observed cooling on the cart on 8/4/25 were left out to cool for a few minutes, temped, and then put in the cooler. DM-H indicated the items observed in the walk-in cooler were pre-cooked and frozen and fish was served every Friday. DM-H indicated frozen, pre-cooked items are pulled from the freezer a few days before they are served and put in the walk-in cooler to thaw. DM-H could not confirm if the following items were dated the day they were cooked, frozen, or pulled from the freezer and put in the walk-in cooler:~ Three steam table containers labeled puree fish (dated 7/18/25)~ Three steam table containers labeled puree peas (dated 7/29/25) ~ Three steam table containers labeled puree turkey dated (7/29/25)DM-H also could not confirm the date the two steam table containers labeled tacos for Tuesday were cooked, cooled, or put in the walk-in cooler and could not identify the contents of the unlabeled steam table container that contained a red sauce, the contents of the undated steam table container labeled for puree, or the date the for puree was cooked, cooled, and put in the cooler. Surveyor and DM-H reviewed the facility's August 2025 food cooling log. Surveyor noted and DM-H confirmed the following items were not documented on the log:~ Two covered and undated steam table containers labeled taco meat for Tuesday~ An undated steam table container labeled for puree that contained what appeared to be roast beef~ An unlabeled plastic container that contained what appeared to be cooked ground meat (dated 8/2/25)~ Two steam table containers of Cream of Wheat and one steam table container each of scrambled eggs and sausage crumblesSurveyor noted the cooling log contained an entry for oatmeal listed as Oat that contained a temperature of 140 degrees F and indicated the oatmeal was 80 degrees F in the 2nd hour of cooling. The log did not indicate the food was cooled to a temperature of 70 degrees F and did not indicate when the cooling process started or ended with a temperature of 80 degrees F.On 8/5/25, Surveyor reviewed the facility's July 2025 food cooling log which did not contain entries for the following items:~ Three steam table containers labeled puree fish (dated 7/18/25)~ Three steam table containers labeled puree peas (dated 7/29/25) ~ Three steam table containers labeled puree turkey (dated 7/29/25)~ Two covered and undated steam table containers labeled taco meat for Tuesday~ An unlabeled steam table container that contained a red sauce (dated 7/3/25)~ An undated steam table container labeled for puree that contained what appeared to be roast beef Expired/Undated/Improperly Stored Foods:During an initial kitchen tour that began on 8/4/25 at 8:09 AM, Surveyor observed the following items in the dry storage area:~ Three undated boxes of Quaker Cream of Wheat~ Five cans of La Choy fancy bean sprouts (dated delivered 10/7/22 with an expiration date of 9/2024)~ Four cans of La Choy chow mein noodles (dated delivered 6/17/22 with an expiration date of 5/7/23)~ One dented can of Musselman's sliced apples~ An undated bin of brown rice that contained a Styrofoam bowl used as a scoop~ A container of white sugar that contained a condiment cup used as scoop~ An unlabeled and undated container of white powder~ Four unlabeled and undated containers of what appeared to be cereal During a continuous kitchen observation that began on 8/5/25 at 10:54 AM, Surveyor and DM-H observed the items listed above in the dry storage area. DM-H indicated the items should not be in the dry storage area and should be discarded. DM-H indicated the container of white powder was thickener used to thicken food and liquid and should be dated. DM-H indicated all food items in the dry storage area, including boxes of food, cereal, and food removed from its original container and stored in another container, should be labeled and dated to ensure safety. DM-H also indicated scoops should not be stored in food containers which is a cross-contamination concern. Surveyor and DM-H also observed the following expired/potentially expired items in the walk-in cooler: ~ A steam table container of red sauce (dated 7/3/25)~ An undated steam table container labeled for pureeDM-H indicated food items put in the walk-in cooler from the freezer or saved as leftovers should be dated and discarded after seven days. DM-H indicated undated food should be discarded. Quaternary Sanitizer:During an initial kitchen tour (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that began on 8/4/25 at 8:09 AM, Surveyor observed a sanitizer log in the dish room. The log contained a spot to document water temperature, however, there were no water temperatures documented. During a continuous kitchen observation that began on 8/5/25 at 10:54 AM, DM-H confirmed the facility uses Hydrion Quaternary test strips to test parts per million (PPM) of the sanitizing solution. Surveyor and DM-H verified the Hydrion Quaternary test strip package insert indicates the water temperature should be between 65 and 75-degree Fahrenheit (F) when the solution is tested for PPM. DM-H indicated the temperature of the water used to mix the sanitizing solution is not tested prior to using the sanitizing solution to sanitize food contact surfaces. Dishwasher (Ware washer) Surface Temperatures:The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual Ware washing: Water temperature is critical to sanitization in ware washing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water used. A temperature measuring device is essential to monitor manual ware washing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the ware washing machine meet or exceed the required 71 C (160 F). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical ware washers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71 C (160 F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71 C (160 F).During an initial kitchen tour that began on 8/4/25 at 8:09 AM, Surveyor observed an August 2025 dishwasher temperature log that indicated to check the surface temperature once daily and document. The log indicated the surface temperature should reach 160 degrees F. Surveyor noted the log did not contain any documented surface temperatures for 8/1/25 through 8/4/25. During a continuous kitchen observation that began on 8/5/25 at 10:54 AM, Surveyor observed DM-H attempt to use a disc to obtain the dishwasher surface temperature, however, DM-H was unable to use the disc and indicated the battery was dead. DM-H was unsure when the battery died and confirmed staff are required to obtain and document surface temperatures daily. Surveyor reviewed the July 2025 dishwasher temperature log and noted all documented daily surface temperatures in July did not reach 160 degrees F. Surveyor reviewed the August 2025 dishwasher temperature log and noted the documented daily surface temperature on 8/5/25 did not reach 160 degrees F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 4 residents (R) (R62, R1, R9, and R42) of 6 sampled residents. During an observation of pericare for R62, Certified Nursing Assistant (CNA)-D did not appropriately remove gloves and cleanse hands.R1 was on enhanced barrier precautions (EBP). During an observation of catheter irrigation, Licensed Practical Nurse (LPN)-G did not wear appropriate personal protective equipment (PPE). Following the provision of care, staff did not remove PPE and complete hand hygiene when exiting R9's room.R42 had a history of chronic urinary tract infections (UTIs). R42's uncovered catheter bag was observed on the floor.Findings include: The facility's Enhanced Barrier Precautions Policy, dated 3/26/24, indicates: It is the policy of this facility that enhanced barrier precautions (EBP) .will be implemented during high-contact resident care activities when caring for residents who have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with chronic wounds requiring a dressing, indwelling medical devices, or residents with infection or colonization with an MDRO .EBP requires gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities. Novel or targeted MDROs include methicillin-resistant Staphylococcus aureus (MRSA), extended-spectrum beta-lactamase (ESBL) producing Enterobacterales .High-contact resident care activities include dressing, bathing/showering, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube), wound care (any skin opening requiring a dressing) .The purpose of EBP is to prevent opportunities for transfer of MDROs to employees' hands and clothing. The facility's Hand Hygiene Policy, revised 5/8/24, indicates: Staff will perform hand hygiene by either using soap and water (when hands are visibly dirty or soiled with blood or other body substances) or alcohol-based hand gel (when hands are not visibly soiled). Hand hygiene should be performed under the following conditions: Before applying gloves and after removing gloves or other personal protective equipment (PPE); After handling items potentially contaminated with blood, body fluids, or secretions; Before moving from a contaminated body site to a clean body site during resident care; example: after providing peri-care, before applying moisture barrier, or other treatments; If exposure to infectious disease is suspected or proven; Before handling clean or soiled dressings, gauze pads, etc.; After contact with inanimate objects in the immediate vicinity of the resident. The facility's Foley Catheter Management Policy, revised 1/28/25, indicates: .4. Catheter bags will be covered at all times. 1.From 8/4/25 to 8/6/25, Surveyor reviewed R62's medical record. R62's most recent admission to the facility was on 8/14/24. R62 had a diagnosis of end stage renal disease (ESRD) and a permacath (a catheter used for dialysis to provide access to the bloodstream for patients with kidney failure) on the right side of the chest. R62 was on EBP. A Minimum Data Set (MDS) assessment, dated 6/4/25, indicated R62 had moderate cognitive impairment. R62 made R62's own healthcare decisions. On 8/5/25 at 2:12 PM, Surveyor observed CNA-D complete pericare for R62. CNA-D donned a gown and gloves prior to initiating care for R62 who was incontinent of bowel and bladder. CNA-D cleansed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R62's buttocks/rectal area which contained a smear of stool then touched R62's clean brief, Chux pad, shirt, bedding, bedside table, water pitcher, and bed control without removing gloves and cleansing hands. On 8/5/25 at 2:24 PM, Surveyor interviewed CNA-D who confirmed CNA-D should have removed gloves and completed hand hygiene after completing pericare. On 8/5/25 at 4:09 PM, Surveyor interviewed Director of Nursing (DON)-B who verified CNA-D should have removed gloves and completed hand hygiene after pericare and before touching R62 and items in R62's environment. 2. On 8/4/25, Surveyor reviewed R1's medical record. R1 had diagnoses including cerebral palsy, delusional disorder, epilepsy, depression and hemiplegia following a cerebral vascular accident. R1 made R1's own medical decisions. An MDS assessment, completed on 5/14/25, indicated R1 had intact cognition. On 8/4/25 at 10:23 AM, Surveyor observed LPN-G completed hand hygiene, don gloves, place a disposable Chux pad on R1's bed, and unhook a catheter from R1's leg. LPN-G then opened 3 normal saline 10 milliliter (ml) syringes and alcohol prep pads. LPN-G removed gloves, completed hand hygiene, and donned clean gloves. LPN-G unhooked a Foley catheter bag from the Foley tubing, placed the tip of the tubing in a basin, cleansed the catheter end and tip of a 10 ml syringe with alcohol, and inserted the syringe into the catheter. LPN-G pushed normal saline into the catheter with no resistance. LPN-G indicated there was usually a better connection, however, LPN-G did not have the correct syringe. LPN-G then wiped the catheter and tubing with an alcohol pad, re-attached them, and secured the tubing to R1's leg. LPN-G removed the basin and Chux pad, removed gloves, and completed hand hygiene. Surveyor noted LPN-G did not wear a gown during the procedure. On 8/4/25 at 10:33 AM, Surveyor interviewed LPN-G who indicated LPN-G should have worn a gown when completing catheter irrigation. On 8/5/25 at 1:44 PM, Surveyor interviewed DON-B who verified LPN-G should have worn a gown when completing catheter irrigation for R1. 3. From 8/4/25 to 8/6/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, ESBL resistance, history of chronic UTIs, and type 2 diabetes. R9's MDS assessment, dated 5/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 had intact cognition. R9's had an activated Power of Attorney for Healthcare (POAHC). A care plan, with a revision date of 2/17/25, indicated R9 was on EBP due to a history of ESBL. On 8/4/25 at 10:20 AM, Surveyor observed an EBP sign on R9's door and a PPE cart outside R9's door. On 8/4/25 at 10:24 AM, Surveyor observed CNA-E exit R9's room in a gown and gloves and enter a utility room. CNA-E disposed of trash and then removed CNA-E's gown and gloves. CNA-E exited the utility room without completing hand hygiene. On 8/4/25 at 11:57 AM, Surveyor interviewed CNA-E who verified CNA-E wore a gown and gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while completing cares in R9's room and exited the room without removing the gown and gloves. CNA-E verified CNA-E should have removed the gown and gloves and completed hand hygiene prior to exiting R9's room. On 8/6/25 at 12:34 PM, Surveyor interviewed DON-B who was aware CNA-E exited R9's room and walked in the hallway without removing PPE. DON-B indicated CNA-E should have disposed of the gown and gloves prior to exiting R9's room. DON-B acknowledged R9 was on EBP and confirmed staff should complete hand hygiene prior to exiting residents' rooms. 4. From 8/4/25 to 8/6/25, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including ESBL resistance, history of chronic UTIs, and flaccid neuropathic bladder. R42's MDS assessment, dated 5/14/25, had a BIMS score of 15 out of 15 which indicated R42 had intact cognition. R42 had an activated POAHC. A care plan, with revision date of 5/12/25, indicated R42 had a Foley catheter related to flaccid neuropathic bladder with history of recurrent ESBL infections. The care plan contained interventions for EBP, educate about transmission of organism, and provide a privacy bag for urine collection. R42 was diagnosed with recurrent urinary tract infections on 1/25/25, 5/2/25, and 6/5/25. On 8/4/25 at 12:54 PM, Surveyor observed R42's uncovered Foley catheter bag on the floor. On 8/6/25 at 12:34 PM, Surveyor interviewed DON-B who indicated catheter bags should be off the floor. DON-B also indicated R42's catheter bag should have been covered with a dignity bag.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R11 and R8) of 4 sampled residents received the necessary care and services to prevent or monitor weight loss.R11 had a significant weight loss of 6.1% from 6/2/25 to 7/1/25. The facility did not implement interventions to address R11's weight loss.R8's medical record indicated R8 had a 7.1% weight loss over a 1 month period. The facility did not address R8's weight loss when it was identified. Findings include: The facility's Resident Height and Weight policy, revised 1/7/25, indicates: .Nursing department, staff, and the Dietitian will cooperate to prevent, monitor, and provide interventions for undesirable weight variances for our residents .A significant weight change is defined as a 5% weight change over 30 days, a 7.5% weight change over 90 days, or a 10% weight change over 180 days .4. All monthly weights are to be completed by the seventh of the month and any reweights needed are to be completed by the 10th of the month .6. Weekly or daily weights are recommended if any of the following are present: .b. Significant unplanned weight loss in 30, 90, or 180 days .8. Any weight change of 5 pounds or greater within 30 days will be retaken within 24 hours for verification and a re-weight will be documented .Once an accurate weight is verified, the inaccurate weight should be struck out with the appropriate explanation .9. If a re-weight verifies a significant, unplanned weight change, it is communicated to the resident's physician, Power of Attorney (POA), dietitian, and any others deemed necessary by the Interdisciplinary Team. The weight change will be addressed and reviewed by the dietitian in cooperation with the Interdisciplinary Team and appropriate interventions will be implemented, reviewed, and revised as needed. Care plan to be updated with interventions provided. 1.From 8/4/25 to 8/6/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, moderate protein-calorie malnutrition, and irritable bowel with constipation. R11's Minimum Data Set (MDS) assessment, dated 7/7/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R11 had moderately impaired cognition. R11 had an activated Power of Attorney for Healthcare (POAHC). R11 was admitted to the facility following a hospitalization from 5/18/25 to 5/21/25 for adult failure to thrive. A care plan, dated 5/23/25 with a revision date of 6/9/25, indicated R11 had a potential for altered nutritional status with a goal to maintain stable nutrition and hydration with no significant weight fluctuations. The care plan contained the following interventions: Regular diet; Provide food choices, Registered Dietitian (RD) to evaluate and recommend diet changes as needed; Report gastrointestinal complaints to nursing; Weigh per facility policy as ordered; Notify Medical Director/Nurse Practitioner per order of with significant changes. R11's medical record contained the following orders: ~ Obtain and record monthly weight. One time a day starting on the 1st and ending on the 2nd every month (dated 6/12/25 with a start date of 7/1/25) ~ Regular diet: Level 7 regular texture, Level 0 thin (regular) consistency (dated 5/21/25) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's medical record contained the following weights: ~ On 8/4/25 at 1:50 PM, R11 weighed 179.1 pounds (standing) ~ On 8/1/25 at 10:42 AM, R11 weighed 177.7 pounds (standing) ~ On 7/1/25 at 11:36 AM, R11 weighed 182.0 pounds (standing) ~ On 6/16/25 at 1:08 PM, R11 weighed 192.7 pounds (standing) ~ On 6/9/25 at 11:35 AM, R11 weighed 193.5 pounds (standing) ~ On 6/2/25 at 12:49 PM, R11 weighed 193.9 pounds (standing) ~ On 5/26/25 at 11:24 AM, R11 weighed 193.0 pounds (standing) ~ On 5/23/25 at 12:50 PM, R11 weighed 193.3 pounds (standing) ~ On 5/21/25 at 8:21 PM, R11 weighed 193.7 pounds (standing) A weight change note, dated 7/3/25 at 11:08 AM and written by Registered Dietitian (RD)-C indicated R11 weighed 182.0 pounds on 7/1/25 which was a 6.1% weight change over 29 days. The note indicated nursing was notified of the need for a re-weigh to verify R11's weight. (R11's next documented weight was on 8/1/25.) On 8/5/25 at 11:24 AM, Surveyor interviewed RD-C who indicated R11 flagged for a significant weight loss on 7/1/25 and RD-C requested a re-weight for R11 on 7/3/25. RD-C indicated R11 was not re-weighed and R11's next weight was on 8/1/25. RD-C verified R11's plan of care had not been revised since 6/9/25 and indicated R11's significant weight loss was discussed with Director of Nursing (DON)-B, R11, and R11's POA on 8/4/25. On 8/6/25 at 12:34 PM, Surveyor Interviewed DON-B who indicated significant weight loss is assessed by RD-C who requests a re-weigh from the nurse. DON-B verified R11's re-weigh was not completed until 8/1/25 and indicated RD-C did not follow-up on R11's weight loss. DON-B confirmed there were no interventions implemented for R11's significant weight loss. 2. On 8/4/25, Surveyor reviewed R8's medical record. R8 had diagnoses including aftercare after joint replacement surgery, depression, history of traumatic brain injury, schizophrenia, and alcohol abuse. R8 made R8's own medical decisions. An MDS assessment, completed on 5/15/25, indicated R8 had intact cognition. R8's medical record indicated R8 weighed 210.4 pounds on 7/1/25 and 195.4 pounds on 8/1/25 which was a 7.1% weight loss in 1 month. A progress note, date 6/20/25 and written by RD-C, indicated R8 had a 10% weight loss over the previous 180 days. The note indicated R8's intake was adequate and the weight loss was favorable. R8's intake percentages indicated R8 consistently ate between 50-100% of meals during July of 2025. R8 did not have any documented issues with diarrhea or vomiting. (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	08/06/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/25 at 2:31 PM, Surveyor interviewed RD-C who verified R8 had a 7.1% weight loss and indicated R8 should have been flagged for weight loss. RD-C indicated RD-C found the flag, however, it had been cleared. RD-C stated only RD-C or another dietitian should clear flags. RD-C indicated when a resident flags for weight loss, RD-C has staff re-weight the resident. RD-C also reviews eating patterns and speaks with nursing staff to identify a potential reason for the weight loss. RD-C indicated RD-C would have R8 re-weighed immediately. On 8/5/25 at 2:54 PM, RD-C informed Surveyor that R8 was re-weighed and R8's current weight was 209.7 pounds which indicated R8 did not have a 7.1% weight loss. On 8/5/25 at 3:09 PM, Surveyor interviewed Registered Nurse (RN)-F who indicated nurses should document weights in a resident's medical record. RN-F indicated if an approximate 15 pound weight loss is identified, the first thing RN-F would do is have staff re-weigh the resident. If the weight was accurate, RN-F would immediately assess the resident and notify the physician. On 8/5/25 at 4:00 PM, Surveyor interviewed DON-B who indicated the nurse who received the weight that indicated R8 had a 15 pound weight loss should have had R8 re-weighed immediately and entered the correct weight in R8's medical record. DON-B indicated nursing staff should notify the physician immediately if the weight loss is accurate.

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	08/06/2025

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R29) of 4 sampled residents was monitored for adverse reactions to antibiotic medication. The facility did not monitor R29 for side effects or adverse reactions to ciprofloxacin (an antibiotic medication).Findings include:The facility's Antibiotic Stewardship Policy, revised 5/8/24, indicates: Purpose: To promote appropriate use of antibiotics for quality of care, successful resident outcomes and reduction of potential adverse consequences related to antibiotic use .7. The nurse will observe and document effectiveness of antibiotics, side effects, and potential adverse consequences .Resident will be observed for potential side effects of the antibiotic. From 8/4/25 to 8/6/25, Surveyor reviewed R29's medical record. R29 was most recently admitted to the facility on [DATE] and had diagnoses including dementia, diabetes, chronic ulcer right lower leg, methicillin-resistant Staphylococcus aureus (MRSA) leg wound, and extended spectrum beta lactamase (ESBL) resistance. R29's Minimum Data Set (MDS) assessment, dated 7/11/25, indicated R29 had intact cognition. R29 made R29's own healthcare decisions.A right lateral shin culture, dated 7/22/25, indicated R29 had MRSA requiring isolation.R29 was prescribed ciprofloxacin HCl oral tablet 500 milligrams (mg) by mouth twice daily for wound infection for 7 days on 7/29/25.A care plan indicated R29 had a history of ESBL. The care plan contained interventions for enhanced barrier precautions (EBP) and antibiotic per Medical Doctor (MD) order. Surveyor noted R29 did not have orders to monitor for side effects or adverse reactions to ciprofloxacin or interventions to do so on R29's care plan. On 8/5/25 at 4:04 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R29 had an order for ciprofloxacin. DON-B confirmed R29 should have orders and interventions in R29's plan of care to monitor for side effects and adverse reactions to ciprofloxacin.