STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525568	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook Sheboygan	3014 Erie Ave Sheboygan, WI 53081

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 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 1 resident (R) (R2) of 3 sampled residents was free from a chemical restraint not required to treat the resident's medical symptoms. The facility did not implement non-pharmacological interventions prior to administering antipsychotic medication to decrease R2's behaviors. Findings Include:The facility's Policy & Procedure Psychotropic Medication, dated 5/1/25, indicates: Purpose: To provide guidance for the psychopharmacologic drug treatment for a resident with a specific condition, including but not limited to dementia and other cognitive disorders, and/or behaviors as documented in the resident's clinical record .1. An assessment must be conducted to identify specific behaviors/symptoms, potential causative factors, and recommendations for managing identified behavior. 2. The medical record documentation must reflect the specific behaviors/symptoms and the resident's response to non-pharmacological interventions to manage the behaviors/symptoms .7. After implementation of psychotropic medication, behavior/symptom and medication side-effects will be monitored and documented. 8. Residents receiving antipsychotic medication will be assessed using the Abnormal Involuntary Movement Scale (AIMS) upon admission or initiation of antipsychotic medication therapy and every six months and upon significant change while remaining on antipsychotic medication therapy. 9. Residents will receive ongoing evaluation to identify possible causes that may be reduced or eliminated through care plan modification. 10. For those residents requiring as needed (PRN) psychotropic medication administration, non-pharmacological interventions need to be attempted and documented prior to medication administration. Residents receive PRN medication only if necessary to treat a diagnosed specific condition that is documented in the clinical record .14. A plan of care will be developed to include precipitating factors, non-pharmacologic interventions, and potential side effects. On 9/3/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of overlapping sites of rectum, anus and anal canal, anxiety disorder, and depression. R2's Minimum Data Set (MDS) assessment, dated 5/31/24, had a Brief Interview for Mental Status (BIMS) score of 00 (not appropriate to assess) out of 15 which indicated R2 had severely impaired cognition. R2 had an activated Power of Attorney of Healthcare (POAHC).R2's medical record contained the following orders:~ Lorazepam oral tablet 1 milligram (mg) - Give 1 tablet by mouth every 2 hours as needed for anxiety, agitation, restlessness (start date 8/26/25).~ Haloperidol oral tablet 1 mg - Give 1 tablet by mouth every 6 hours for restlessness and agitation (start date 8/26/25). ~ Haloperidol oral tablet 2 mg - Give 1 tablet by mouth every 6 hours for restlessness and agitation (start date 9/3/25).R2's Kardex (an abbreviated care plan used by nursing staff) contained the following: ~ Frequent monitoring for increased anxiety or restlessness.~ Monitor for Target Behaviors - 1. Social isolation interventions for behaviors: Encourage (R2) to participate in social activities of choice.A care plan, dated 6/12/25, indicated R2 was at high risk for falls related to weakness, cancer, and heart disease. The care plan contained the following interventions:~ Check on (R2) every 2 hours while in bed for safety (initiated 5/20/25)~ Bed controller out of reach related to cognition (initiated 4/29/25)~ Bolster mattress (initiated 4/14/25)~ Encourage (R2) to use call light for assistance (initiated 3/13/25); Sign in room to use call light when assistance is needed (initiated 3/13/25)~ Frequent monitoring for increased anxiety or restlessness (initiated 6/1/25)~ (R2) moves (R2's) self from lowest bed position to floor mattress, sometimes to floor (initiated 8/1/25)~ Staff to ensure (R2) is lying in the center of the bed (initiated 3/13/25)~ Toileting schedule implemented (initiated 3/13/25)~ While (R2) is up and out of bed, place in common area for supervision (initiated 4/16/25)~ Implement sensory strategies to meet sensory needs. (Stimulation of the 5 senses, beware of over-stimulating. Agitation may be a sign that sensory stimulation should be changed. Sensory activities: walking, conversation, music, [NAME] lamp/light show, tasting/eating/snacking, aromatherapy, nail care/hand massage, bath, weighted blanket, fidget pads, sensory boards) (initiated 4/8/24)~ Provide/offer snacks in between meals and/or with signs of restlessness (initiated 4/8/24)~ Encourage to wear gripper socks when up (initiated 3/13/25); Fall mat at bedside (initiated 5/7/24); Ensure the environment is free of clutter (initiated 4/1/24).R2 was assessed for anxiety disorder. Interventions included:~ Monitor for Target Behaviors - 1. Social isolation interventions for behaviors: Encourage (R2) to participate in social activities of choice (initiated 4/8/25).~ Monitor/document/report PRN any adverse reactions to anti-anxiety medications: drowsiness, lack of energy, clumsiness, slow refluxes, slurred speech, confusion, disorientation, depression, dizziness, lightheadedness, impaired thinking and