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	12/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. (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 0580 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 staff and resident representative interview and record review, the facility did not notify a Guardian of a change in condition or a need to alter treatment for 1 resident (R) (R1) of 1 sampled resident.R1 eloped from the facility on 11/27/25. R1's Guardian was not notified of the elopement until 12/1/25.R1 fell on [DATE] at 11:20 AM and 7:28 PM. R1's Guardian was not notified of the second fall.Findings include:The facility's Elopement Risk and Prevention policy, dated 6/2/22, indicates: .Procedure for Missing Residents and/or Elopements: .3. Contact the resident's family or responsible party .The facility's Acute Care Transfer policy, dated 9/15/21, indicates: .4. Notification shall be made to the durable power of attorney/responsible party for any change in condition, including those requiring transfer to an acute care facility .On 12/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, post-traumatic stress disorder (PTSD), delirium, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 11/2/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severe cognitive impairment. R1 had a court-appointed Guardian.On 12/8/25, Surveyor reviewed an elopement investigation that indicated the facility could not determine how R1 eloped from the facility on 11/27/25 without staffs' knowledge. Staff last saw R1 between 3:30 and 3:40 PM. Staff were not aware that R1 had eloped until police arrived at the facility at approximately 5:15 PM and stated R1 was discovered in the parking lot of a nearby hospital. R1's Guardian was not notified of the elopement until 12/1/25. On 12/9/25 at 10:00 AM, Surveyor interviewed Guardian (GD)-G who stated R1's family notified GD-G on the morning of 12/1/25 that R1 had eloped from the facility on 11/27/25. GD-G also received an email from Adult Protective Services (APS) with a copy of the police report and left a message for the facility's Social Worker on 12/1/25. Nursing Home Administrator (NHA)-A returned the call shortly afterward. When GD-G indicated GD-G heard about the elopement from R1's family, NHA-A apologized for the late notification and stated staff were busy with an admission and did not notice R1 leave. NHA-A indicated the facility would notify the State Agency (SA) and ensure R1 did not elope again.On 12/9/25, Surveyor reviewed two fall reports for R1 that were dated 12/1/25. The first report indicated R1 was in a recliner in the common area on 12/1/25 at 11:15 AM when R1 woke up and started walking down the west infirmary hall toward R1's room. At ll:20 AM, a Certified Nursing Assistant (CNA) witnessed R1 lose balance and fall on R1's right side. R1 did not hit R1's head and was able to move all extremities without pain or discomfort. R1's vital signs were stable. Staff brought R1 to R1's room, provided care, and took R1 to the dining room for lunch. R1's family sat with R1 during lunch and notified staff that R1 complained of right hip pain. A Nurse Practitioner (NP) ordered a stat (immediate) X-ray. GD-G was notified. A second fall report indicated R1 fell again at 7:28 PM. The report indicated GD-G was called at 8:40 PM when R1's X-ray showed a right hip fracture and the NP requested that R1 be sent to the hospital. GD-G gave verbal consent for a bed hold.A nursing progress note, dated 12/1/25 at 7:28 PM, indicated Licensed Practical Nurse (LPN)-H heard R1 yell from down the hallway and observed R1 sitting on the floor next to the foot of R1's bed. R1's right shoe was off. R1 grimaced and stated, I was sitting on my bed playing Solitaire. I got excited during the game and slid off my bed. LPN-H assisted R1 to a supine position on the floor and assessed R1 for pain or injury. R1 stated the top of R1's right thigh/hip was painful and throbbing. LPN-H ensured R1 was positioned safely and had staff help transfer R1 to bed. LPN-H then obtained R1's vital signs, completed neuro and accuchecks, and assessed R1's right upper thigh/hip. LPN-H noted an existing yellow/pink bruise on R1's upper right thigh, relieved R1's hip pain with a pillow, and contacted the NP for pain medication. On 12/9/25 at 11:54 AM, Surveyor interviewed GD-G who stated GD-G was notified on 12/1/25 at 1:37 PM that R1 fell that morning and complained of right hip pain and an X-ray was ordered. GD-G received a second call at 8:40 PM and was told R1's X-ray showed a fractured hip. GD-G gave permission to transfer R1 to the hospital. GD-G stated the facility did not inform GD-G that R1 sustained a second fall on 12/1/25 at 7:28 PM. On 12/9/25 at 2:15 PM, Surveyor interviewed NHA-A who stated NHA-A called GD-G about the elopement on 11/27/25 but received a voice message that did not include GD-G's name and did not feel comfortable leaving a message. NHA-A called GD-G again on 12/1/25 regarding the elopement; however, R1's family had already notified GD-G. NHA-A was aware staff notified GD-G about the first fall and contacted GD-G again that evening regarding the need to send R1 to the hospital. NHA-A was not aware that GD-G was not informed of R1's second fall and indicated staff should notify responsible parties of all falls.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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) (R1) of 3 sampled residents was assessed following a fall with injury prior to being transferred from the floor into bed.R1 sustained a fall with injury on 12/1/25 at 11:20 AM. An X-ray was ordered and pending review. R1 sustained a second fall with reported pain on 12/1/25 at 7:28 PM. R1 was transferred from the floor into bed with the use of Hoyer slings without a physical assessment to ensure R1 was medically safe to be transferred. Findings include:The facility's Post Fall policy, dated 10/13/23, indicates: .Evaluation: Before moving the resident, ask the resident what they believe caused the fall and assess any associated symptoms. Then conduct a comprehensive evaluation .Be aware of the following warning signs: numbness or tingling in the extremities, back pain, rib pain, or an externally rotated or shortened leg. These symptoms suggest spinal cord injury, leg or pelvic fracture, or head injury. If symptoms are noted, resident should not be moved from current position. Update provider immediately or call 911 .On 12/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, post-traumatic stress disorder (PTSD), delirium, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 11/2/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severe cognitive impairment. R1 had a court-appointed Guardian.A nursing progress note, dated 12/1/25 at 7:28 PM, indicated Licensed Practical Nurse (LPN)-H heard R1 yell from down the hallway and observed R1 sitting on the floor next to the foot of R1's bed. R1's right shoe was off. R1 grimaced and stated, I was sitting on my bed playing Solitaire. I got excited during the game and slid off my bed. LPN-H assisted R1 to a supine position on the floor and assessed R1 for pain or injury. R1 stated the top of R1's right thigh/hip was painful and throbbing. LPN-H ensured R1 was safely positioned and had staff help transfer R1 to bed with Hoyer slings. LPN-H then obtained R1's vital signs, completed neuro and accuchecks, and assessed R1's right upper thigh/hip. LPN-H noted an existing yellow/pink bruise on R1's upper right thigh, relieved R1's hip pain with a pillow, and contacted a Nurse Practitioner (NP) for pain medication. On 12/9/25 at 3:36 PM, Surveyor interviewed LPN-H who stated R1 complained of hip pain and wanted to lay down when LPN-H found R1 sitting on the floor on 12/1/25 at 7:28 PM. LPN-H was worried that R1 would lay down or move on R1's own so LPN-H assisted R1 to a supine position and called for assistance. LPN-H indicated three staff put the same color Hoyer slings underneath R1 and lifted R1 into bed. LPN-H then completed a physical assessment of R1. On 12/9/25 at 4:01 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility's policy indicates not to move a resident who had a fall with injury until staff complete vital signs and skin and pain assessments. Staff can then transfer the resident unless there is visible blood, bone, or dislocation. NHA-A stated R1 was not in severe pain and had no signs of a fracture. Range of motion was completed and R1 was able to move all extremities without pain or discomfort. R1 did not hit R1's head. NHA-A stated R1's family told the nurse that R1 had right hip pain and the facility obtained an order for an X-ray. NHA-A was not aware that the injury information was for R1's first fall and that R1 sustained a second fall at 7:28 PM. While waiting for the results of the pending X-ray, staff transferred R1 (who complained of pain) from the floor to the bed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure adequate supervision was provided for 1 resident (R) (R1) of 3 residents reviewed for elopement.R1's care plan upon admission on [DATE] indicated R1 was at risk for wandering/elopement. A WanderGuard (a security device that triggers an alarm if the wearer exits the facility) was placed on R1's right ankle. On 11/27/25, R1 attempted to exit the unit multiple times and was redirected by staff. The facility did not implement increased supervision for R1. On 11/27/25 at 5:15 PM, the police department notified the facility that R1 was found 0.6 miles from the facility in a hospital parking lot. Staff were unaware R1 had left the facility. An investigation indicated R1 exited through a second-floor stairwell door with a functioning alarm. Another resident's family member silenced the alarm and informed staff, who were busy with other residents. Staff did not follow the facility's procedure to conduct a head count when notified of the alarm.The facility's failure to provide adequate supervision for a resident at risk for elopement and with a history of exit seeking and staffs' failure to follow the facility's elopement procedure created a finding of immediate jeopardy that began on 11/27/25. Nursing Home Administrator (NHA)-A was notified of the the immediate jeopardy on 12/9/25 at 4:40 PM. The immediate jeopardy was removed on 12/9/25; however, the deficient practice continues at a scope/severity level E (potential for more than minimal harm/pattern) as the facility continues to implement it's action plan.Findings include: The facility's Elopement Risk and Prevention policy, dated 6/2/22, indicates: .3. The Administrator and Director of Nursing will be notified immediately of any concerns with secured doors or keypads .5. At no time shall a door alarm be turned off without the continual supervision of the exit .Procedure for Missing Residents and/or Elopements: .3. Contact the resident's family or responsible party .Procedure on How to Respond When an Armed Door Alarms: 1. All stuff must respond immediately to any door alarm. 2. Staff must identify which door was triggered. 3. Notify the Administrator and Director of Nursing that an exit door alarm was triggered. Staff responding to a door alarm must open the alarming door and check the outside of the building and immediate surrounding area to make sure no resident exited the building through that door. 4. Unit nurse must immediately conduct a head count of all residents on the unit to make sure everyone is accounted for. Report the final count to the Director of Nursing/designee. 5. If a resident is identified as missing (a resident who has left the facility without signing themselves out of the facility or has wandered away from the facility), initiate the following steps: a. Notify the Administrator and Director of Nursing immediately b. Notify the Charge Nurse c. Call a Code Yellow (missing resident).On 12/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, post-traumatic stress disorder (PTSD), delirium, and anxiety. R1's Minimum Data Set (MDS) assessment, dated 11/2/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severe cognitive impairment. R1 had a court-appointed Guardian.A care plan, revised 10/27/25, indicated R1 was at risk for elopement/wandering/leaving the facility without notice. R1 had a WanderGuard. The care plan indicated it was unsafe for R1 to leave the unit on R1's own due to Alzheimer's dementia and an inability to recognize safety risks.R1's medical record indicated R1 was found on 11/27/25 at approximately 4:45 PM in a hospital parking lot. R1 told hospital staff R1 was going to the dentist and walked from across town. R1 then stated R1 drove but locked the keys in R1's car at the dentist's office. R1 did not remember the name of the dentist or where the office was located. R1 did not have a coat. (According to weatherunderground.com, the temperature at the time R1 left the facility was approximately 25 degrees with wind gusts around 22 miles per hour.) R1 was seen in the waiting room and initially declined Emergency Department (ED) evaluation; however, R1 appeared confused and required an evaluation under the Emergency Medical Treatment and Active Labor Act (EMTALA) (a federal law that requires Medicare-participating hospitals to provide emergency medical screening and stabilizing treatment to anyone with an emergency medical condition regardless of their insurance, etc.) R1 was assessed and had no injuries. R1 provided R1's name and date of birth . R1's spouse was contacted and indicated R1 must have eloped from the nursing home's dementia unit. The hospital attempted to call the facility but there was no answer. Hospital staff then called the police. Surveyor reviewed a map of the city and noted the hospital was 0.6 miles from the facility. Surveyor noted R1 would have walked down a busy street with numerous stop lights and under an overpass with limited sidewalk areas before reaching the hospital parking lot. A police report, dated 11/27/25, indicated the police went to the facility and informed staff that R1 was found wandering in a hospital parking lot. R1 was identified

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe manner. This practice had the potential to affect all 65 residents residing in the facility. Food temperatures logs were incomplete for items served to residents.Beverage temperatures were greater than 41 degrees Fahrenheit (F) prior to serving residents on the third floor.Findings include:The Wisconsin Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) . Time/temperature control for safety food shall be maintained: (1) 135 degrees F or above, except that roasts cooked to a temperature and for a time specified in paragraph 3-401.11 (B) or reheated as specified in paragraph 3-403.11 (E) may be held at a temperature of 130 degrees F or above; or (2) At 41 degrees F or less.On 12/8/25 and 12/9/25, Surveyor observed the second and third floor November and December 2025 food temperature logs in the second and third floor dining rooms. The logs were undated and contained missing documentation. Surveyor noted the following on the third floor dining room food temperature log:~ Week of 11/1/25 to 11/7/25: No meal temperatures were recorded on 11/4/25; No breakfast or lunch temperatures were recorded on 11/5/25; No lunch or dinner temperatures were recorded on 11/6/25; No dinner temperatures were recorded on 11/2/25 and 11/3/25; No beverage temperatures were recorded from 11/1/25 to 11/7/25.~ Week of 11/16/25 to 11/22/25: No lunch temperatures were recorded on 11/18/25; No dinner or beverage temperatures were recorded from 11/16/25 to 11/22/25.~ Week of 11/23/25 to 11/29/25: No meal temperatures were recorded from 11/25/25 to 11/26/25; No breakfast or lunch temperatures were recorded on 11/23/25; No dinner temperatures were recorded from 11/24/25 to 11/29/25; No beverage temperatures were recorded from 11/23/25 to 11/29/25.~ Three undated food temperature documents contained multiple missing food temperatures and no beverage temperatures.Surveyor noted the following on the second floor dining room food temperature log:~ Week of 11/2/25 to 11/8/25: No meal temperatures were recorded on 11/3/25 and 11/8/25; No lunch temperatures were recorded on 11/7/25; No dinner or beverage temperatures were recorded from 11/2/25 to 11/8/25.~ Week of 11/9/25 to 11/15/25: No meal temperatures were recorded from 11/10/25 to 11/15/25; No dinner temperatures were recorded on 11/9/25; No beverage temperatures were recorded from 11/9/25 to 11/15/25.~ Week of 11/16/25 to 11/22/25: No breakfast or lunch temperatures were recorded from 11/18/25 to 11/22/25; No dinner temperatures were recorded on 11/20/25; No beverage temperatures were recorded from 11/16/25 to 11/22/25.~ Week of 11/23/25 to 11/30/25: No breakfast or lunch temperatures recorded from 11/28/25 to 11/30/25; No dinner temperatures were recorded on 11/23/25 or from 11/25/25 to 11/29/25; No beverage temperatures were recorded from 11/23/25 to 11/30/25.~ Week of 12/8/25: No dinner temperatures were recorded on 12/8/25; No beverage temperatures were recorded on 12/8/25.~ One undated food temperature document contained multiple missing food temperatures and no beverage temperatures.On 12/9/25 at 11:52 AM, Surveyor interviewed Dietary Aide (DA)-K who indicated DA-K is present to temp food prior to serving breakfast and lunch. DA-K indicated food temperature logs should be filled out for breakfast, lunch, and dinner for starch, meat, vegetables, and beverages. Surveyor reviewed the incomplete food temperature logs with DA-K who indicated DA-K worked at the facility part-time and was not present for dinner. DA-K indicated it is the responsibility of the aides who serve the food at dinner to temp the food prior to serving. On 12/9/25 at 11:52 AM, Surveyor observed lunch in the third floor dining room and observed DA-K obtain beverage temperatures prior to lunch service. DA-K indicated hot food from the steam table should have a temperature greater than 135 degrees F prior service and beverage temperatures should be above 40 degrees F per the Wisconsin Food Code and the facility's policy. Surveyor observed DA-K temp apple juice in a pitcher on the serving cart and verified the apple juice was 48 degrees F. Surveyor observed DA-K temp a glass of freshly poured chocolate milk and verified the milk was 48.4 degrees F. Surveyor also observed DA-K temp white milk on the serving cart and verified the milk was 49 degrees F. On 12/9/25 at 2:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated it is the responsibility of the cooks and aides to temp food and beverages prior to meal service. Surveyor reviewed the incomplete food logs with NHA-A who indicated staff education was provided related to food temperature logs in October due to a grievance. Surveyor reviewed the signed education that was provided on 10/13/25 NHA-A indicated the Dietary Manager was at the facility 2 to 3 days per week. NHA-A stated the facility did not have a policy regarding food temperatures and staff should follow the Wisconsin Food Code for temping food and beverages.