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	02/04/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure the right to participate or designate others to participate in the care planning process for 3 residents (R) (R2, R3, and R5) of 5 sampled residents.Quarterly care conferences were not offered for R2, R3, and R5 in the last year.Findings include:The facility's Care Conference policy, revised 6/20/23, indicates the purpose is to provide interdisciplinary communication with the resident and/or legal representative for purposes of the development of an individualized plan of care. It also indicates the resident and/or their responsible party will receive communication in advance of the scheduled care conference .The Interdisciplinary Team (IDT) shall consist of, but is not limited to: Minimum Data Set (MDS) coordinator, nursing representative, therapy representative, activity representative, social services representative, and dietary representative. The IDT will review some of the following in preparation for the care conference: falls, restraints, psychotropic medications, wounds, labs, advanced directives, immunizations, care plan/Certified Nursing Assistant (CNA) Kardex (an abbreviated care plan used by nursing staff), weight loss/gain, and physician orders. The Care Conference User Defined Assessment (UDA) will be completed in the electronic health record for attendance tracking and record of discussion.1.From 2/3/26 to 2/4/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, dementia, obsessive compulsive disorder (OCD), anxiety, depression, osteoarthritis, and chronic pain. R2's most recent Minimum Data Set (MDS) assessment, dated 12/18/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R2 had moderate cognitive impairment. R2 had a Guardian.On 2/4/26, Surveyor reviewed care conference documentation for R2 and noted that in the last year, R2 had care conferences on 2/25/25 and 11/12/25. R2's medical record did not indicate any other care conferences were offered or declined in the last year.On 2/4/26 at 10:43 AM, Surveyor left a voicemail for R2's Guardian regarding care conferences. As of this writing, a return call was not received. R2's medical record did not indicate R2's Guardian was invited to quarterly care conferences.(See interviews under example 3.)2. From 2/3/26 to 2/4/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia, hemiplegia of the left side, type 2 diabetes, mood disorder, and chronic kidney disease. R3's most recent MDS assessment, dated 1/23/26, had a BIMS score of 10 out of 15 which indicated R3 had moderate cognitive impairment. R3 had an activated Power of Attorney for Healthcare (POAHC).On 2/4/26, Surveyor reviewed care conference documentation for R3 and noted that in the last year, R3 had a care conference on 1/29/26. R3's medical record did not indicate any other care conferences were offered or declined in the last year.On 2/4/26 at 11:01 AM, Surveyor left a voicemail for R3's POAHC regarding care conferences. As of this writing, a return call was not received. R3's medical record did not indicate R3's POAHC was invited to quarterly care conferences. (See interviews under example 3.)3. From 2/3/26 to 2/4/26, Surveyor reviewed R5's (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record. R5 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, history of stroke, and type 2 diabetes. R5's most recent MDS assessment, dated 12/13/25, had a BIMS score of 10 out of 15 which indicated R5 had moderate cognitive impairment. R5 had an activated POAHC.On 2/4/26, Surveyor reviewed care conference documentation for R5 and noted that in the last year, R5 had a care conference on 4/21/25. R5's medical record did not indicate any other care conferences were offered or declined in the last year.On 2/4/26 at 10:15 AM, Surveyor interviewed POAHC-C regarding R5's care at the facility. POAHC-C stated POAHC-C had not been invited to a care conference for R5 in almost a year. POAHC-C had never refused a care conference and wanted to have a care conference to discuss R5's care.On 2/4/26 at 12:38 PM, Surveyor interviewed Social Worker (SW)-D who stated the timing of care conferences is personalized for each resident and dependent on their needs. SW-D verified care conferences should include the resident or their representative and the Interdisciplinary Team (IDT). SW-D stated SW-D documents assessments/notes that review the resident's plan of care but does not consistently use the Care Conference UDA per the facility's policy. On 2/4/26 at 2:14 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified care conferences should be attempted at least quarterly and upon request. NHA-A stated SW-D should use the Care Conference UDA per the facility's policy.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure adequate supervision and assistive devices to prevent accidents were provided for 4 residents (R) (R1, R2, R3, and R5) of 4 sampled residents. R1 fell on 1/10/26. R1's post-fall assessments did not start until 1/12/26. In addition, three of 8 post-fall assessments did not include an updated set of vital signs (VS). In addition, an intervention for gripper socks was not added to R1's care plan.R2 fell on [DATE], 12/2/25, and 12/10/25. Ten of 31 documented post-fall assessments did not include an updated set of VS. R3 fell twice on 11/27/25 while reaching for items. Three of 10 documented post-fall assessments did not include an updated set of VS. In addition, R3 did not have grabbers within reach on 2/4/26 in accordance with R3's care plan.R5 fell on [DATE]. Three of 10 documented post-fall assessments for R5 did not include an updated set of VS. In addition, a call for assisstance reminder sign was not posted in R5's room on 2/4/26 in accordance with R5's care plan. Findings include:The facility's Fall Prevention, Post Fall, and Communication policy, dated 1/21/26, indicates fall prevention interventions will be individualized by the Interdisciplinary Team (IDT) and must be implemented consistently. For monitoring and re-evaluation post-fall, staff should document on a resident's condition at a minimum of every shift for 72 hours. Staff should document relevant post-fall clinical findings such as vital signs, pain, swelling, bruising, and changes in function or cognitive status. Care plans will be updated to include new or revised interventions.1. From 2/3/26 to 2/4/26, Surveyor reviewed R1's medical reocrd. R1 was admitted to the facility on [DATE] and had diagnoses including dementia, hypertension, anxiety, and hemiplegia (loss of motor function) of the right side. R1's most recent Minimum Data Set (MDS) assessment, dated 1/7/26, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R1 had severe cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC) and discharged from the facility on 1/22/26.R1's most recent comprehensive care plan, initiated on 1/7/26, indicated R1 was at high risk for falls related to cognitive impairment with behaviors and weakness. The care plan also indicated R1 was at risk for bleeding and excessive bruising related to anticoagulant (blood thinner) therapy. A nursing note, dated 1/10/26 at 3:58 AM, indicated staff observed R1 on R1's back on the floor with the bottom of R1's bare feet facing the side of the bed. R1 was incontinent of urine and unable to tell staff what happened.A fax to the physician, dated 1/10/26, did not indicate that R1 was on anticoagulant medication. Surveyor reviewed R1's fall investigation, dated 1/10/26, which indicated R1 had an unwitnessed fall in R1's room. The root cause was due to R1's impulsive behavior, decreased safety awareness, and cognitive impairment. An immediate intervention was added to ensure gripper socks were on both feet. (Of note: R1's care plan, revised 1/28/26, did not contain the intervention.)Surveyor reviewed R1's post-fall assessments (which did not start until 1/12/26 at approximately 5:00 AM which was 48 hours post-fall). R1's medical record did not contain any post-fall assessments between 1/10/26 and 1/12/26. Surveyor noted the following post-fall assessments did not include an updated set of VS:~ On 1/13/26 at 1:50 AM, R1's VS were taken from 1/12/26 at 10:07 PM (3 hours and 43 minutes prior to the assessment).~ On 1/14/26 at 6:57 PM, R1's VS were taken from 1/14/26 at 12:04 AM (18 hours and 53 minutes prior to the assessment).~ On 1/15/26 at 6:32 PM, R1's VS were from 1/15/26 at 2:48 AM (15 hours and 44 minutes prior to the assessment).(See interviews under example 4.)2. From 2/3/26 to 2/4/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, anxiety, depression, and chronic pain. R2's most recent MDS assessment, dated 12/18/25, had a BIMS score of 11 out of 15 which indicated R2 had moderate cognitive (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment.R2's most recent comprehensive care plan, initiated on 1/7/26, indicated R2 was at high risk for falls related to Parkinson's disease, neuropathy, and dementia with impaired safety awareness. Surveyor reviewed R2's fall investigation, dated 11/28/25, which indicated R2 had an unwitnessed fall in R2's room at approximately 12:00 PM. The root cause was due to R1's impaired safety awareness and attempt to self-transfer. A Certified Nursing Assistant (CNA) Fall Investigation form, which included the last interaction with R2, items within reach, toileting plan, care plan, and areas for improvement was not completed during the investigation. Surveyor reviewed R2's post-fall assessments and noted the following assessments did not include an updated set of VS:~ On 11/30/25 at 9:19 AM, R2's VS were taken from 11/30/25 at 1:30 AM (7 hours and 49 minutes prior to the assessment).~ On 12/2/25 at 10:16 AM, R2's VS were taken from 12/2/25 at 1:01 AM (9 hours and 15 minutes prior to the assessment).Surveyor reviewed R2's fall investigation, dated 12/2/25, which indicated R2 had an unwitnessed fall in R2's room at approximately 1:40 PM. The root cause of the fall was due to R2's attempt to self-transfer into bed. Surveyor reviewed R2's post-fall assessments and noted the following assessments did not include an updated set of VS:~ On 12/2/25 at 5:27 PM, R2's VS were taken from 12/2/25 at 1:01 AM (16 hours and 26 minutes prior to the assessment).~ On 12/3/25 at 1:03 PM, R2's VS were taken from 12/3/25 at 4:20 AM (8 hours and 43 minutes prior to the assessment). ~ On 12/4/25 at 11:41 AM, R2's VS were taken from 12/3/25 at 4:20 am (1 day, 7 hours, and 21 minutes prior to the assessment).~ On 12/4/25 at 1:40 PM, R2's VS were taken from 12/3/25 at 4:20 AM (1 day, 9 hours, and 20 minutes prior to the assessment).~ On 12/5/25 at 9:24 PM, R2's VS were from 12/5/25 at 1:00 PM (8 hours and 24 minutes prior to the assessment).Surveyor reviewed R2's fall investigation, dated 12/10/25, which indicated R2 had an unwitnessed fall in R2's room at approximately 3:15 PM. The root cause of the fall was due to R2 reaching for something on the floor. On 2/3/26, Surveyor reviewed R2's post-fall assessments and noted the following assessments did not include an updated set of VS:~ On 12/11/25 at 3:17 PM, R2's VS were taken from 12/11/25 at 9:57 AM (5 hours and 20 minutes prior to the assessment).~ On 12/12/25 at 8:41 AM, R2's VS were taken from 12/11/25 at 11:17 PM (9 hours and 24 minutes prior to the assessment).~ On 12/12/25 at 12:42 PM, R2's VS were taken from 12/11/25 at 11:17 PM (13 hours and 25 minutes prior to the assessment).(See interviews under example 4.)3. From 2/3/26 to 2/4/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including hemiplegia of the left side, dementia, diabetes, and mood disorder. R3's most recent MDS assessment, dated 1/23/26, had a BIMS score of 10 out of 15 which indicated R3 had moderate cognitive impairment. R3's most recent comprehensive care plan, revised on 11/5/25, indicated R3 was at moderate risk for falls related to left-sided weakness and dementia with impaired safety awareness. Surveyor reviewed R3's fall investigations for two separate falls on 11/27/25. The investigations, dated 11/27/25, indicated R3 had unwitnessed falls in R3's room at approximately 10:20 AM and 5:30 PM. Both falls occurred when R3 reached for an item. An intervention was added on 12/1/25 to have two reachers within reach in R3's room. Surveyor reviewed R3's post-fall assessments and noted the following assessments did not include an updated set of VS:~ On 11/29/25 at 1:46 PM, R3's VS were taken from 11/29/25 at 2:07 AM (11 hours and 39 minutes prior to the assessment).~ On 11/30/25 at 1:39 PM, R3's VS were taken from 11/30/25 at 4:17 AM (9 hours and 22 minutes prior to the assessment).~ On 12/1/25 at 12:13 AM, R3's VS were taken from 11/30/25 at 4:17 AM (19 hours and 56 minutes prior to the assessment).On 2/4/26 at 12:01 PM, Surveyor observed R3 in a wheelchair in the middle of R3's room. R3's reachers were on opposite sides of R3 against the wall (one was next to R3's bed and one was on top of supplies next to the TV). When Surveyor asked about the reachers, R3 demonstrated that R3 could not reach either one.On 2/4/26 at 12:25 PM, Surveyor and Director of Nursing (DON)-B (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verified both reachers were not within R3's reach. DON-B stated the reachers should be within R3's reach at all times.(See interviews under example 4.)4. From 2/3/26 to 2/4/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, diabetes, and stroke. R5's most recent MDS assessment, dated 12/13/25, had a BIMS score of 10 out of 15 which indicated R5 had moderate cognitive impairment.R5's most recent comprehensive care plan, revised on 5/22/25, indicated R5 was at moderate risk for falls related to weakness and dementia. Surveyor reviewed R5's fall investigation, dated 12/27/25, which indicated R5 had an unwitnessed fall in R5's room at approximately 3:35 AM and could not recall what happened. An intervention for a reminder to call for assistance before getting up sign in R5's room was added to R5's care plan on 12/30/25.Surveyor reviewed R5's post-fall assessments and noted the following assessments did not include an updated set of VS:~ On 12/27/25 at 12:46 PM, R5's VS were taken from 12/27/25 at 3:47 AM (8 hours and 59 minutes prior to the assessment). ~ On 12/29/25 at 1:32 AM, R5's VS were taekn from 12/28/25 at 6:25 PM (7 hours and 7 minutes prior to the assessment).~ On 12/30/25 at 9:07 AM, R5's VS were from 12/30/25 at 1:07 AM (8 hours prior to the assessment).On 2/4/26 at 10:54 AM, Surveyor observed R5 in a chair in R5's room. Surveyor did not observe a reminder to call for assistance sign in the room.On 2/4/26 at 12:25 PM, Surveyor and DON-B observed R5's room. DON-B stated the reminder sign was hung near R5's calendar but must have been taken down or misplaced. DON-B was not sure how long the sign had been missing.On 2/3/26 at 2:11 PM, Surveyor interviewed Registered Nurse (RN)-E who stated the facility's policy was to check on the resident once or twice per shift and not do neurological checks. RN-E stated RN-E would document VS and any changes in a progress note.On 2/3/26 at 2:14 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated the facility still does the standard post-fall neurological checks (every 15 minutes x 4, every 30 minutes x 4, every 60 minutes x 2, and then once per shift). LPN-F stated LPN-F would also obtain a set of VS for each assessment.On 2/4/26 at 12:43 PM, Surveyor interviewed DON-B who verified the facility's policy indicates staff should do an assessment once per shift unless otherwise ordered by the provider. DON-B stated if a resident is on anticoagulant medication, staff should let the provider know because the provider will likely send the resident to the emergency room (ER) for evaluation or order close monitoring due to an increased risk of bleeding.