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	07/01/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide basic life support to a resident in accordance with physician orders and an advance directive for 1 resident (R) (R2) of 6 sampled residents.R2 was enrolled in Hospice services and was discovered pulseless and nonbreathing on [DATE]. At the time of the incident, R2 was a full code. Staff failed to check R2's code status, provide cardiopulmonary resuscitation (CPR) and basic life support, or call 911. The facility's failure to provide CPR/basic life support and call 911 for a full code status resident created a finding of immediate jeopardy that began on [DATE]. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on [DATE] at 10:30 AM. The immediate jeopardy was removed and corrected on [DATE] and is being cited at past non-compliance. Findings include: The facility's Code Status policy, revised [DATE], indicates the purpose of the policy is to ensure advance directives for residents are individualized by/for the resident, documented, and effectively implemented at the facility .The facility will: verify the presence of advance directives or the resident's wishes regarding CPR upon admission. If the resident's wishes are different than the admission orders .will be documented in the resident's medical record following obtaining a physician order for code status .If a resident becomes unresponsive (either witnessed or unwitnessed), the resident's advance directive will be followed . R2 had diagnoses including peritoneal abscess, type 2 diabetes, and severe-protein calorie malnutrition. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], stated R2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. R2 was their own decision maker. R2's medical record indicated they were full code status (signed and dated [DATE]). R2 enrolled in Hospice services on [DATE]. A facility-reported incident (FRI) and Deficient Practice document submitted to the State Agency (SA) indicated Certified Nursing Assistant (CNA)-G and CNA-H provided a bed bath for R2 on [DATE] at approximately 9:00 PM. Registered Nurse (RN)-E entered the room to complete a skin check and replace the dressing on R2's buttocks. Immediately following the dressing change, R2 began having loose stools. RN-E left the room to retrieve additional wound supplies while CNA-G and CNA-H completed cares. During cares, CNA-H thought R2 passed away and left the room to alert RN-E who returned to the room to assess R2. RN-E indicated R2 was unresponsive without observable respirations or signs of life. RN-E thought R2's code status changed from full code to do not resuscitate (DNR) when R2 started Hospice services. RN-E did not initiate CPR or call a code blue. RN-E asked Licensed Practical Nurse (LPN)-F to inform Hospice of R2's passing. The Deficient Practice document indicated R2's code status was accurately documented in their medical record, physician orders, and care plan. The investigation indicated RN-E responded to the event and was aware R2 was a full code status but failed to initiate CPR as required by the facility's policy, professional standards of practice, and R2's documented wishes. The facility determined that the deficient practice was not related to inaccurate code status documentation, the availability of code status information, or Hospice enrollment but rather the failure of RN-E to follow established emergency response procedures. RN-E was immediately removed from resident care and suspended pending completion of the investigation. The FRI and Deficient Practice document included (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff education and signature sheets, code status audits, emergency response competencies for licensed staff, competency drills, mock emergency code drills, and CPR certification documentation for nursing staff. In addition, the facility reviewed records of recent residents' deaths to ensure advance directives were followed. The facility was in compliance as of [DATE]. On [DATE] at 3:06 PM, Surveyor interviewed RN-I who indicated if a resident is found unresponsive, staff should complete an assessment and check the resident's electronic health record (EHR) for their code status. On [DATE] at 3:10 PM, Surveyor interviewed Licensed Practical Nurse Extern (LPNE)-J who indicated they were a CNA but were in training to become an LPN. LPNE-J indicated a nurse should be informed if a resident is found unresponsive and stated they would inform the charge nurse immediately if they discovered an unresponsive resident. LPNE-J indicated the nurse should confirm the resident's code status, assess the resident, and provide the necessary care. On [DATE] at 3:13 PM, Surveyor interviewed LPN-K who indicated nurses are responsible for checking code status and following the order if a resident is found unresponsive. LPN-K verified nursing staff received training on code status and indicated code status is found in a resident's EHR. On [DATE] at 2:30 PM, Surveyor interviewed NHA-A who indicated at approximately 6:30 AM on [DATE], they received a call from the AM nurse who informed them of R2's passing and that RN-E did not follow R2's code status. NHA-A stated an investigation was started and an inital report was submitted to the SA. NHA-A indicated the investigation revealed RN-E did not follow the facility's policy to verify a resident's code status and did not provide CPR as indicated per R2's advance directive. RN-E indicated they thought R2's code status had changed due to enrollment in Hospice services. NHA-A also stated LPN-F was employed through a staffing agency and was asked not to return to the facility. NHA-A indicated immediate education was provided, competency drills, audits, and monitoring were initiated, and the facility's systematic process would be reviewed in upcoming QAPI meetings. The failure to provide CPR/basic life support and call 911 for a full code status resident who was discovered pulseless and non-breathing created a reasonable likelihood for serious harm for R2 thus leading to a finding of immediate jeopardy. The facility removed and corrected the jeopardy on [DATE] when it completed the following:Re-educated facility, agency, and contracted nursing staff on CPR requirements, resident rights regarding code status, emergency response procedures, and requirements to initiate CPR for residents designated as full code, including residents receiving Hospice services.Completed an audit of resident code status documentation to verify code status was accurately reflected throughout the medical record and physician orders.Completed mock code drills on all shifts to validate staff competency in emergency response procedures.Reinforced expectations regarding immediate response to cardiopulmonary arrest and adherence to advance directives.Reviewed CPR certification for nursing staff.