

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook Sheboygan		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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, interview and record review, the facility did not ensure food was served and stored in a safe and sanitary manner. This practice had the potential to affect 59 of 60 residents residing in the facility. (One resident received all nutrition through a feeding tube.) Staff did not properly label, date, or store food in a manner to ensure food safety. Testing and documentation of parts per million (PPM) of the sanitizing solution were not accurately completed. Kitchen equipment and food services areas were not in a clean and sanitary condition. Staff did not follow safe food cooling protocol. Staff did not reheat food served to a resident in accordance with their policy. Findings include: On 7/6/26 at 9:02 AM, Surveyor and Dietary Manager (DM)-C began an initial tour of the kitchen. DM-C stated the facility follows the Federal Food and Drug Administration (FDA) Food Code. Food Labeling/Dating/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (Celsius) (41 F) (Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). The facility's Food Safety Requirement policy, revised 12/23/25, indicates: It is the policy of this company that all facilities provide safe and sanitary storage, handling, and consumption of all foods. This includes the storage, preparation, distribution, and serving of food in accordance with professional standards for food service safety. The Centers for Medicare and Medicaid Services (CMS) recognizes the U.S. Food and Drug Administration (FDA) Food Code and the Centers for Disease Control and Prevention's (CDC's) Food Safety Guidance as national standards to procure, store, prepare, distribute, and serve food in long term care facilities in a safe and sanitary manner. The Facility's Sanitation and Cleaning Schedule policy, revised 8/15/23, indicates: .Storage (refrigerated) .All refrigerated and prepared food must be covered, labeled, and dated with a use-by date that is a maximum of 7 days from the date of preparation. The label must include the name of the food and the date by which it should be used. During the initial kitchen tour with DM-C on 7/6/26, Surveyor observed the following food storage concerns: Coolers:- An unsealed 5 pound bag of shredded parmesan cheese that was open to air with an open date of 6/25 (per DM-C) (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 no use-by date.~ A bag of shredded mozzarella cheese with an open date of 6/25 (per DM-C) and no use-by date.~ An opened bag of sliced Swiss cheese without an open or use-by date. ~ An open container of cream cheese with an open date of 6/7 (per DM-C) and no use-by date.~ An open container of cottage cheese with an open date of 6/7 (per DM-C) and no use-by date. ~ A container labeled blushing pears with an open/made date of 6/4 (per DM-C) and no use-by date. Surveyor interviewed DM-C who stated all open or made food should contain open/made and use-by dates. When asked the use-by dates for the above items, DM-C stated the use-by/discard date is 7 days from the open/made date. Freezers:~ An unlabeled pan of macaroni and cheese (per DM-C) without an open/made or use-by date.~ An open bag of blueberries without an open or use-by date. ~ In the walk-in freezer, Surveyor and DM-C observed ice drips from the ceiling fans in the back of the freezer. Food was stored on shelves under the left side of the dual fan ceiling unit. Ice was observed on a bag of tater tots, an open box of pancakes, and a container of English muffins. Piles of ice were also observed on the freezer floor. Surveyor interviewed DM-C who stated food should not be stored under the fans which were dripping liquid. DM-C stated the food would be discarded and a maintenance request would be completed. DM-C was not sure of the use-by dates for the above items observed in the freezers. Sanitizing Solution: The 2022 FDA Food Code documents at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization-Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the Environmental Protection Agency (EPA)-registered label use instructions. The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. A posted TMA Quaternary Sanitizer data sheet indicated the sanitizing solution should be tested for effectiveness between 65 and 75 degrees Fahrenheit (F) to accurately measure the parts per million (PPM). Hydriion Quat test strips used to test the sanitizing solution indicate the solution temperature should be tested and be within 65-75 degrees F. The effective PPM range is 150-400. The Facility's Sanitation and Cleaning Schedule policy, revised 8/15/23, indicates: .5. The sink sanitizer log must be completed per policy for both three and four-compartment manual warewashing sinks and buckets or spray bottles filled with Quat sanitizer and reviewed daily. 6. Any temperatures that are out of compliance must be addressed immediately . During the initial kitchen tour with DM-C on 7/6/26, Surveyor noted temperatures on the sanitizing solution testing log were out of range for the solution and testing strips used by the facility. Surveyor and DM-C reviewed the log and Hydriion test strip and TMA Quat sanitizer information. The log indicated the sanitizing solution should be between 75 and 110 degrees F. The Hydriion test strip and TMA Quat sanitizer information indicated the sanitizing solution should be between 65 and 75 degrees F when testing PPM effectiveness. DM-C stated the facility's log was incorrect and would be corrected. On 7/7/26 at 9:32 AM, Surveyor reviewed the July 2026 sanitizing solution testing log which was posted in the kitchen. The log indicated the solution in the 3-compartment sink and sanitizing buckets used to clean/sanitize the kitchen was tested twice daily. The top of the sheet indicated the temperature of the sanitizing solution should be between 75 and 110 degrees F. All the documented temperatures were between 104 and 112 degrees F. On 7/8/26 at 9:39 AM, Surveyor asked [NAME] (CK)-I to test the sanitizing solution. CK-I tested the temperature of the solution in the 3-compartment sink which was 104 degrees F. CK-I dipped a test strip in the solution for approximately 10 seconds and compared the strip to the color legend on the back of the test strips container. CK-I stated the PPM were 400. When Surveyor asked if CK-I was aware of the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cooled within specified guidelines for the prevention of foodborne illness. Procedure: 1. Cooked TCS foods shall be cooled under refrigeration within 2 hours from 135 F or greater to 70 F and within a total of 6 hours from 135 F or greater to 41 F or less. 2. Temperatures of TCS foods placed in cooler shall be recorded by the cook on the Cooling Food Temperature Log . During the initial kitchen tour with DM-C on 7/6/26, Surveyor observed the July 2026 food cooling log that was posted in the kitchen. The log did not contain any items for cooling. Surveyor interviewed DM-C who stated the log was not correct. Surveyor and DM-C noted the following foods were cooked and stored in July 2026 and should have been on the log: ~ Chicken Kiev, 7/5/26~ Broccoli, 7/1/26~ Cheese omelettes, 7/5/26~ Pork, 7/5/26 Reheating Procedure: The 2022 FDA Food Code documents at 3-401.12 Microwave Cooking: The rapid increase in food temperature resulting from microwave heating does not provide the same cumulative time and temperature relationship necessary for the destruction of microorganisms as do conventional cooking methods. In order to achieve comparable lethality, the food must attain a temperature of 74 degrees C (165 degrees F) in all parts of the food. Since cold spots may exist in food cooked in a microwave oven, it is critical to measure the food temperature at multiple sites when the food is removed from the oven and then allow the food to stand covered for two minutes post microwave heating to allow thermal equalization and exposure. Although some microwave ovens are designed and engineered to deliver energy more evenly to the food than others, the important factor is to measure and ensure the final temperature reaches 74 degrees C (165 degrees F) throughout the food. The 2022 FDA Food Code documents at 3-403.11 Reheating for Hot Holding (B): .Time/Temperature control for safety food reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. The facility's Reheating Food policy, dated 2/25/25, indicates: .Per ServSafe, all food heated in a microwave must be heated to 165 F for a minimum of 15 seconds, but no higher than 180 F .Food must be stirred to distribute heat and allowed to sit for at least 2 minutes before retesting the temperature . On 7/7/26 at 8:55 AM, Surveyor observed Licensed Practical Nurse (LPN)-F heat a plate of food in the microwave. The food was immediately delivered to a resident. The temperature was not obtained prior to delivery. In addition, the food was not stirred and did not sit for the required 2 minutes before the temperature was tested and the food was served. On 7/7/26 at 8:56 AM, Surveyor interviewed LPN-F who verified they reheated food for a resident. LPN-F stated the plate was nice and hot so they knew the food was nice and hot for the resident also. On 7/8/26 at 2:04 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated kitchen staff should be aware of and follow all policies related to food preparation, storage, safety, cleanliness, and serving.		

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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, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 60 residents residing in the facility. Staff did not offer residents hand hygiene before a meal. R8 was on enhanced barrier precautions (EBP) due to a feeding tube. Staff flushed R8's feeding tube without donning the appropriate personal protective equipment (PPE). Findings include: The Centers for Disease Control and Prevention (CDC) About Handwashing information from CDC.gov dated 2/16/24 indicates: Many diseases and conditions are spread by not washing hands with soap and clean, running water. Hand washing with soap is one of the best ways to stay healthy. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surface to person when you: Touch your eyes, nose, and mouth with unwashed hands; Prepare or eat food and drinks with unwashed hands; Touch surfaces or objects that contain germs; Blow your nose, cough, or sneeze into your hands and then touch other peoples' hands or common objects. You can keep yourself and your loved ones healthy by washing your hands often, especially during these key times when you are likely to get and spread germs: Before, during, after preparing food; Before and after eating food . The facility's Enhanced Barrier Precautions (EBP) Policy & Procedure, dated 3/26/24, indicates: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities .3. EBP is used in conjunction with standard precautions and expands the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staffs' hands and clothing .5. For residents for whom EBP is indicated, EBP is employed when performing the following high-contact resident care activities: Device care or use: central line, urinary catheter, feeding tube . On 7/7/26, Surveyor requested a policy for hand hygiene at meals. The policy that was provided did not contain hand hygiene information. 1. On 7/7/26 at 8:00 AM, Surveyor observed the second floor main dining room where 20 residents were eating/being served breakfast. Surveyor observed Certified Nursing Assistant (CNA)-D and CNA-E assist 8 residents into the dining room and help them prepare for breakfast. The residents were offered clothing protectors and drinks prior to the meal. The residents were not offered hand hygiene prior to or after the meal. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/7/26 at 8:40 AM, Surveyor interviewed R37 who stated they were not offered hand hygiene before meals but would like to be offered. On 7/7/26 at 9:00 AM, Surveyor interviewed R31 who stated they were not offered hand hygiene at breakfast. On 7/7/26 at 9:13 AM, Surveyor interviewed R19 who stated they were not offered hand hygiene before or after breakfast. R19 stated they can get an extra napkin if they want but staff don't wash their hands and sometimes the food is sticky. R19 stated staff could at least provide a wipe or something to clean their hands with but they would prefer staff wash their hands. On 7/7/26 at 9:15 AM, Surveyor interviewed Family Member (FM)-G who was assisting R33 with breakfast. FM-G stated R33 was not offered hand hygiene prior to breakfast. FM-G stated they assist R33 with meals daily and hand hygiene is not offered. FM-G stated they wash R33's hands because staff do not do so. On 7/7/26 at 10:45 AM, Surveyor interviewed FM-H who stated they visit R33 often. FM-H stated staff do not offer to wash R33's hands before or after meals. FM-H stated they have to wash R33's hands. On 7/7/26 at 1:00 PM, a Resident Council meeting was conducted with Surveyors in attendance. During the meeting, R3, R13, R19, R35, R38, R51, and R56 stated they are not offered hand hygiene before meals but would like to be offered. On 7/7/26 at 1:23 PM, Surveyor interviewed CNA-D who verified they did not offer hand hygiene to residents in the dining room prior to or after breakfast. CNA-D was unsure why hand hygiene was not offered. On 7/8/26 at 8:19 AM, Surveyor interviewed R3 who stated they are not offered hand hygiene before meals but would like to be offered. On 7/8/26 at 2:04 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated staff should offer hand hygiene to residents prior to and after meals. 2. R8 was admitted to the facility on [DATE], had a diagnosis of dysphagia oropharyngeal, and required a feeding tube. A care plan, dated 7/6/26, indicated R8 was on EBP due to a feeding tube. On 7/7/26 at 2:16 PM, Surveyor observed Licensed Practical Nurse (LPN)-O flush R8's feeding tube with a syringe. LPN-O did not wear a gown as required by the facility's EBP policy. On 7/7/26 at 2:22 PM, Surveyor interviewed LPN-O who indicated they did not have to wear a gown to flush R8's feeding tube. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/7/26 at 3:02 PM, Surveyor interviewed NHA-A who confirmed after reviewing the facility's EBP policy that LPN-O should have worn a gown when flushing R8's feeding tube.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility did not ensure adequate supervision and assistive devices to prevent accidents were provided for 1 resident (R) (R11) of 5 sampled residents. R11 fell on 3/3/26 and 5/15/26. Post-fall assessments for the 3/3/26 fall did not start until 3/4/26. Two post-fall assessments were not completed. In addition, two post-fall assessments for the 5/15/26 fall were not completed. 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. R11 was admitted to the facility on [DATE] and had diagnoses including cognitive impairment, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure with hypoxia and supplemental oxygen. A Minimum Data Set (MDS) assessment, dated 5/9/26, stated R11 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating intact cognition. A care plan, dated 5/9/26, indicated R11 was at high risk for falls related to cognitive issues, weakness, and respiratory failure with equipment management needs and often got up alone without assistance. Risk versus benefits education related to self-transferring was completed. A nursing note, dated 3/3/26 at 10:51 PM, indicated staff observed R11 sitting on the floor in their room with their back facing the nightstand and feet facing the wheelchair. R11 stated they tripped over their oxygen tubing. Surveyor reviewed R11's post-fall assessments which did not start until 3/4/26 at approximately 7:00 AM (8 hours post-fall.) In addition, R11's medical record did not contain post-fall assessments for the 3/5/26 or 3/6/26 night (NOC) shifts. A nursing note, dated 5/15/26 at 7:14 AM, indicated staff observed R11 sitting on their buttocks leaning against their bed at 4:55 AM. R11 stated they lost their balance on the way to the bathroom, fell onto their right side, and grabbed the curtain on the way down. R11 denied hitting their head. R11's medical record did not contain post-fall assessments for the 5/16/26 NOC shift or on 5/18/26. On 7/8/26 at 1:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated residents are monitored via post-fall assessments. NHA-A stated neuro checks are not completed unless ordered by the provider. NHA-A verified R11 had multiple missing post-fall assessments. NHA-A stated staff should document post-fall assessments every shift for at least 72 hours post-fall. On 7/8/26 at 1:28 PM, Surveyor interviewed Director of Nursing (DON)-B who stated nurses should document post-fall assessments every shift for the next 72 hours.		

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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 interview and record review, the facility did not ensure feeding assistance was provided for 2 residents (R) (R24 and R23) of 3 sampled residents. Staff did not provide feeding assistance for R24 and R23 in accordance with their plans of care. In addition, R24 and R23's Minimum Data Set (MDS) assessments and plans of care contained inconsistent information regarding their feeding requirements. Findings include: The facility's Activities of Daily Living policy, revised 2/25/25, indicates: Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure a resident's abilities in activities of daily living (ADLs), do not diminish unless circumstances of the resident's clinical condition demonstrate that such diminution was avoidable .2. The facility will provide services for the following activities of daily living: .Eating: Assistance with feeding or preparation of meals .3. Based on the assessment, a personalized care plan is created. It outlines the level of assistance needed .The care plan is adjusted over time as a resident's condition changes. 4. Residents' abilities to perform ADLs will be monitored for evidence of any decline and appropriate interventions put in place as applicable. 5. ADLs will be individualized considering factors like physical abilities, cognitive function, and mental health. ADL cares will be provided based on resident preferences. 6. Resident ADL care needs will be communicated to staff via the care plan and Kardex.1. R24 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, frontotemporal neurocognitive disorder, moderate protein-calorie malnutrition, vascular dementia, abnormal weight loss, dysphagia, and delirium. An MDS assessment, dated 5/8/26, stated R24's Brief Interview for Mental Status (BIMS) score was not assessed. The assessment indicated R24 required partial/moderate feeding assistance. R24 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. R24's care plan indicated they had the potential for altered nutritional status related to frontal neurological disorder, altered mental status, dysphagia, and Parkinson's disease and required extensive assistance and a sectioned plate to assist with loading utensil to eat. R24 required assistance to self-feed to prevent food from falling off the utensil. The goal indicated R24 would accept assistance with meals as needed.R24's Kardex (an abbreviated care plan used by nursing staff) indicated they required extensive assistance with eating. A weight change note on 7/6/26 at 11:01 AM by the Registered Dietitian indicated R24 was down 6.4 lbs or 4.3% in the past month.On 7/7/26 at 12:25 PM, Surveyor observed R24 feeding themself with their left fingers. R24's meal was on a divided plate, however, they could not reach the food on the left side of the plate and ate the food closet to them. R24 pulled a paper placemat to the edge of the table. At 12:53 PM, Certified Nursing Assistant (CNA)-D asked another staff to turn R24's plate around so it was within reach. R24 attempted to eat mashed potatoes by tipping the plate forward and used their right pointer finger to eat the potatoes until the plate slid from the table and leaned into R24's lap. R24 also attempted to eat pieces of meat with their left hand while the plate was on their lap. At 1:09 PM, CNA-D sat down to assist R24 with eating mashed potatoes and apple pie and drinking a beverage.On 7/7/26 at 9:12 AM, Surveyor interviewed POAHC-N who stated they come to the facility every day for breakfast and supper to feed their spouse (R20) who would not be fed adequately if they were not present. POAHC-N stated they observed many residents sit at the dining table and wait to be fed for up to an hour. POAHC-N stated they observed staff give residents a spoonful of food as they walked past while completing other tasks. POAHC-N also stated they observed residents not being fed meals. POAHC-N stated there is not enough staff for the number of residents who require feeding (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Edenbrook Sheboygan		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance. On 7/8/26 at 2:38 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R24 is not assessed as needing feeding assistance. On 7/8/26 at 3:30, Surveyor interviewed Nursing Home Administrator (NHA)-A who acknowledged the inconsistency in R24's feeding assistance care plan, Kardex, and MDS assessment. 2. R23 was admitted to the facility on [DATE] and had diagnoses including dementia and white matter disease. An MDS assessment, dated 5/7/26, stated R23's BIMS score was not assessed. The assessment indicated R23 required substantial/max feeding assistance. R23 had an activated POAHC to assist with healthcare decisions. A care plan, revised 6/12/26, indicated R23 had the potential for altered nutritional status related to dementia, white matter disease, and alcohol abuse and required supervision, placement of utensil in the right hand, encouragement for intake, plate set-up, food cut in bite-sized pieces, and open containers. The goal indicated R23 would maintain stable nutrition and hydration with no significant weight fluctuations. R23's Kardex indicated they required supervision with eating. On 7/7/26 at 12:03 PM, Surveyor observed R23 at a dining room table. At 12:39 PM, Surveyor observed R23 at the table with a covered plate. Licensed Practical Nurse (LPN)-F asked if R23 was going to eat their meal. CNA-D was feeding another resident and stated R23's plate was covered because they needed assistance. At 12:41 PM, Surveyor observed R23 at the table with a covered plate and observed 7 other residents eating lunch around them. At 12:45 PM, R23 attempted to uncover their plate. At 12:47 PM, CNA-D moved R23's dishes to the other side of the table, moved R23's chair, uncovered their food, and began to feed them. At 1:07 PM, R23 was finished eating. On 7/8/26 at 8:22 AM, Surveyor observed LPN-M feed R23 in a wheelchair. LPN-M stated R23 required verbal prompts to eat. LPN-M stated R23 was physically able to eat finger foods but was not able to eat foods that required utensils. On 7/8/26 at 11:30 AM, Surveyor interviewed DON-B who stated R23 did not need to be fed and could independently eat finger foods. On 7/8/26 at 3:30 PM, Surveyor interviewed NHA-A who acknowledged the inconsistency in R23's feeding assistance care plan, Kardex, and MDS assessment.		

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NAME OF PROVIDER OR SUPPLIER Edenbrook Sheboygan		STREET ADDRESS, CITY, STATE, ZIP CODE 3014 Erie Ave Sheboygan, WI 53081	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the accurate administration of medication for 1 resident (R) (R38) of 18 sampled residents. R38 used an insulin pump to administer insulin at the bedside 3 times daily. R38 did not have a self-administration of medication assessment, an order to self-administer medication, or an order to administer insulin via pump. In addition, staff did not document the insulin administration in R38's Medication Administration Record (MAR). Findings include: The facility's Medication Self-Administration policy, dated 3/1/24, indicates: 1. The resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medication. 2. The ability to self-administer medication will indicate: a. Able to self-administer medication independently; b. Able self-administer medication with supervision, cueing, and/or set-up; c. Not able to self-administer medication safely; 3. Residents who have been deemed appropriate to self-administer medication independently or with supervision/cueing or after set-up shall have a physician order to do so. 4. The resident's service plan will be updated with their ability to self-administer medication. 5. The Self-Administration Screen will be re-evaluated annually and more frequently as clinically indicated. The facility's Medication Administration policy, dated 5/20/23, indicates: When administration of medication or treatment/therapy is delegated or assigned to unlicensed personnel (ULP), the facility will ensure the Registered Nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the medication or perform treatment, and the ULP has demonstrated the ability to competently follow the procedures. 2. Specified, in writing, specific instructions for each resident and documented the instructions in the resident's record. Prior to a ULP providing delegated medication administration and/or treatment, the following must occur: 1. An RN must conduct a face-to-face assessment to determine what medication management or treatment services will be provided and how. 2. The facility will prepare and include in the service plan a written statement of the medication management or treatment services to be provided. 3. The medications have current prescriber's orders on file. 4. An RN must specify in writing specific instructions for each resident and document the instructions in the resident's record. 5. An RN must instruct the ULP on the following medication administration tasks before delegating the task to them: a) The complete procedure of checking a resident's medication administration record (MAR); b) The preparation of medication for administration; c) The administration of the medication to the resident; d) The reminder to self-administer medication; e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered. 6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment to an RN. 7. Written records signed by an RN shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment. The facility's Insulin Administration with Pump policy, dated 6/30/25, indicates: 2. Insulin will be administered via provider orders. 3. The resident will be assessed for awareness of hypoglycemia and hyperglycemia symptoms; the ability to calculate and deliver bolus doses; suspend insulin delivery; and ability to refill the pump. R38 was admitted to the facility on [DATE] and had diagnoses including type 1 diabetes mellitus and presence of insulin pump. A Minimum Data Set (MDS) assessment, dated 6/6/26, stated R38 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. A care plan, revised 6/11/26, indicated R38 had type 1 diabetes mellitus and an (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Edenbrook Sheboygan		STREET ADDRESS, CITY, STATE, ZIP CODE 3014 Erie Ave Sheboygan, WI 53081	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insulin pump per physician order (dated 6/16/26). The care plan did not contain interventions related to the insulin pump. R38's medical record did not contain an order for the insulin pump or orders for insulin dosing via the pump. R38's medical record also did not contain an order for self-administration of medication or a self-administration of medication assessment. R38's MAR did not indicate insulin was administered. On 7/6/26 at 11:38 AM, Surveyor interviewed R38 who stated they had a continuous glucose meter that monitored their blood glucose level. R38 stated staff ask about their blood glucose level when necessary and R38 verbally communicates the information. R38 stated they independently dose short-acting Novolog insulin via the pump. R38 stated they dose insulin with meals by counting carbs and entering the number of carbs in the pump. R38 stated staff do not ask about the insulin dose and they do not communicate the dose to staff. Surveyor observed staff enter R38's room and ask about their blood glucose level which R38 provided. Surveyor observed R38 dose insulin via the pump. On 7/6/26 at 1:30 PM, Surveyor interviewed Director of Nursing (DON)-B about R38's insulin orders. DON-B stated they would provide the information to Surveyor. On 7/7/26, Surveyor reviewed an insulin pump order in R38's medical record (dated 7/7/26) that indicated: Insulin pump orders: Carb ratio: 2.6 g/u (grams per unit). Sensitivity: 30 milligrams/deciliter (mg/dL) per U blood glucose target: 110-120 mg/dL Bolus Increment: 0.1 U Max Basal: 5.0 U/Hr Max Bolus: 25 U Bolus Speed: Quick Current High Limit: 250 mg/dL Rise Alert: 4.0 mg/dL/min Current Low Limit: 80 mg/dL. On 7/7/26 at 1:45 PM, Surveyor interviewed R38 and Family Member (FM)-P who stated they order insulin pump supplies and change insulin infusion sites as directed by R38's endocrinologist. FM-P stated staff have called them to come to the facility, including in the middle of the night, to assist with the pump, trouble shoot, and/or change the infusion site when it gets pulled out. R38 stated they are comfortable using the insulin pump and prefer to dose insulin that way. On 7/8/26 at 9:08 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who verified the new order in R38's medical record for the insulin pump. LPN-L verified there had not been an order for the insulin pump since LPN-L started in 5/2026. LPN-L stated R38 manages the pump and staff contact FM-P to come to the facility if the pump requires trouble shooting. LPN-L stated staff ask R38 for their blood glucose level and document it in their medical record. LPN-L verified staff do not document the insulin R38 doses via the pump. LPN-L stated staff give verbal report to the next shift to ask R38 for their blood glucose level and communicate the presence of the continuous glucose monitor and insulin pump. On 7/8/26 at 1:27 PM, Surveyor interviewed DON-B who verified R38 had an insulin pump and managed it independently. DON-B confirmed FM-P assists with the pump as needed. DON-B indicated the Assistant Director of Nursing (ADON) obtained an order for the insulin pump on 7/7/26 because the facility did not have a prior order. DON-B verified R38 had the insulin pump since they were admitted to the facility on [DATE].		