STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525307	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook of Green Bay	2961 St Anthony Dr Green Bay, WI 54311

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain dignity during meal time for 3 residents (R) (R22, R29, and R59) of 4 sampled residents.R22, R29, and R59 required assistance with eating. On 8/26/25, staff moved between R22, R29, and R59 (who were at different tables) while providing assistance with breakfast and stood while feeding them.Findings include:From 8/25/25 to 8/27/25, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, dementia, cancer, end stage renal disease, diabetes, and hemiplegia/hemiparesis. R22's Minimum Data Set (MDS) assessment, dated 6/23/25, indicated R22 was rarely or never understood. From 8/25/25 to 8/27/25, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including muscular dystrophy, calorie deficit at risk for malnutrition, and Friedreich's ataxia. R29's MDS assessment, dated 8/11/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R29 had severely impaired cognition.From 8/25/25 to 8/27/25, Surveyor reviewed R59's medical record. R59 was admitted to the facility on [DATE] and had diagnoses including severe dementia with psychotic disturbance, schizoaffective disorder, panic disorder, and anxiety. R59's MDS assessment, dated 8/25/25, had a BIMS score of 3 out of 15 which indicated R59 had severely impaired cognition.On 8/26/25 at 8:08 AM, Surveyor observed 14 residents in the second-floor main dining room during breakfast and witnessed the following:~ At 8:10 AM, Surveyor observed Certified Nursing Assistant (CNA)-J walk up to and feed R59 one spoonful of food while standing. CNA-J assisted R59 for one to two minutes then walked away to assist R29 at another table. CNA-J applied a clothing protector to R29 then fed R29 a bite of food while standing. CNA-J then walked to R22 at another table and fed R22 one bite of food while standing. CNA-J then walked back to R29 and continued to feed R29 bites of food while standing. ~ At 8:16 AM, Surveyor observed CNA-J retrieve a char and sit down to feed R29. ~ At 8:26 AM, Surveyor observed CNA-J stand up and continue to feed R29 until R29 was finished eating.~ At 8:31 AM, Surveyor observed CNA-J walk to R22, feed R22 a couple bites of food while standing, and then walk away. ~ At 8:34 AM, Surveyor observed CNA-J walk back to R22 and continue to feed R22 until R22 was finished. On 8/26/25 at 8:34 AM, Surveyor interviewed CNA-P who identified the residents and staff observed in the dining room and indicated Surveyor's observation was a typical occurrence during dining room service.On 8/26/25 at 2:18 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff should sit down while feeding residents. On 8/26/25 at 2:24 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should not stand while feeding residents. DON-B indicated staff should be aware of and follow the facility's expectations for serving food and assisting residents.On 8/26/25 at approximately 3:30 PM, Surveyor interviewed Registered Dietitian (RD)-Q who indicated staff should sit down while feeding residents for safety and dignity.Surveyor requested policies from NHA-A and DON-B regarding the resident dining experience and/or feeding of residents by staff. No applicable policies were provided.

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 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 provide the necessary care and services to maintain the highest practicable physical well-being for 3 residents (R) (R65, R52, and R9) of 3 sampled residents.Staff did not update the provider with a weight gain of 3 pounds or more in one day or 5 pounds or more in one week as ordered for R65, R52, and R9. Findings include: The facility's Heart Failure policy, dated 3/19/24, indicates: .2. In addition, the nurse will assess and document/report the following: .b. Daily weights or as ordered by the provider .i. Call for weight gain of 3 pounds or greater in 24 hours or 5 pounds in one week or as directed by the provider .d. Provider will be updated with changes in condition . 1. From 8/25/25 to 8/27/25, Surveyor reviewed R65's medical record. R65's most recent admission to the facility was on 7/15/25. R65 had diagnoses including chronic systolic congestive heart failure (CHF), acquired absence of left leg below knee, and diabetes mellitus type 2. R65's Minimum Data Set (MDS) assessment, dated 8/6/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R65 had intact cognition. R65's plan of care indicated R65 had altered cardiovascular status related to heart failure (initiated on 4/8/25) and contained interventions to monitor/document/report as needed (PRN) .changes in weight. R65's physician orders, dated 7/15/25, indicated the following: ~CHF monitoring: Monitor respiratory status, edema, fatigue, and change in mental status every shift and document findings in electronic health record (EHR). Update provider with any signs/symptoms of worsening CHF. ~Daily weights upon admission for residents with heart failure unless directed otherwise by provider. Call for weight gain of 3 pounds or greater in 24 hours or 5 pounds in one week unless otherwise directed by the provider. Surveyor reviewed R65's weights for 6/1/25 to 8/25/25 and noted the following: ~ On 6/5/25, R65 weighed 273.2 pounds.~ On 6/6/25, R65 refused to be weighed.~ On 6/7/25, R65 weighed 279.6 pounds (which was a gain of 6.4 pounds). ~ On 6/9/25, R65 weighed 279.6 pounds.~ On 6/10/25, R65's weight was not recorded~ On 6/11/25, R65 weighed 284.0 pounds. ~ On 6/12/25, R65 weighed 286.2 pounds (which was a gain of 6.6 pounds). ~ On 6/14/25, R65 weighed 280.2 pounds.~ On 6/15/25, R65 weighed 284.4 pounds (which was a gain of 4. 2 pounds). ~ On 6/20/25, R65 weighed 270.4 pounds.~ On 6/25/25, R65 weighed 278.7 pounds (which was a gain of 8. 3 pounds). (continued on next page)

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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	~ On 7/21/25, R65 weighed 263.9 pounds.~ On 7/22/25, R65 weighed 269.0 pounds (which was a gain of 5. 1 pounds). ~ On 7/27/25, R65 weighed 267.0 pounds.~ On 7/28/25, R65 weighed 261.6 pounds (which was a loss of 5. 4 pounds). ~ On 7/31/25, R65 weighed 263.4 pounds.~ On 8/1/25, R65 weighed 268.2 pounds (which was a gain of 4.6 pounds). ~ On 8/8/25, R65 weighed 263.4 pounds.~ On 8/9/25, R65 weighed 270.8 pounds (which was a gain of 7.4 pounds). ~ On 8/16/25, R65 weighed 234.6 pounds.~ On 8/17/25, R65 weighed 267.6 pounds (which was a gain of 33 pounds). ~ On 8/18/25, R65 weighed 263.2 pounds.~ On 8/19/25, R65 weighed 268.8 pounds (which was a gain of 5. 6 pounds). ~ On 8/21/25, R65 weighed 259.6 pounds.~ On 8/22/25, R65 weighed 269.4 pounds (which was a gain of 9. 8 pounds). Surveyor noted R65's medical record did not indicate the provider was updated when R65 gained 3 or more pounds in 24 hours or 5 or more pounds in one week. 2. From 8/25/25 to 8/27/25, Surveyor reviewed R52's medical record. R52 was admitted to the facility on [DATE] and had diagnoses including CHF and diabetes. R52's MDS assessment, dated 8/7/25, had a BIMS score of 15 out of 15 which indicated R52 had intact cognition. R52's plan of care indicated R52 had potential for altered nutritional status related to recent surgery and contained interventions to weigh R52 per facility policy or as ordered and notify the provider per order or with significant changes. R52's physician orders, dated 7/25/25, indicated the following: ~ CHF monitoring: Monitor respiratory status, edema, fatigue, and change in mental status every shift and document findings in EHR. Update provider with any signs/symptoms of worsening CHF. ~ Daily weights for residents with heart failure. Call for weight gain of 3 pounds or greater in 24 hours or 5 pounds in one week unless otherwise directed by the provider. Surveyor reviewed R52's weights for 7/24/25 to 8/25/25 and noted the following: ~ On 7/30/25, R52 weighed 286.0 pounds. ~ On 7/31/25, R52 weighed 290.2 pounds (which was a gain of 4. 2 pounds). ~ On 8/1/25, R52 weighed 286.0 pounds.~ On 8/2/25, R52 weighed 293.3 pounds (which was a gain of 7.3 pounds). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ On 8/24/25, R52 weighed 288.3 pounds.~ On 8/25/25, R52 weighed 292.9 pounds (which was a gain of 4. 6 pounds). Surveyor noted R52's medical record did not indicate the provider was notified when R52 gained 3 or more pounds in 24 hours or 5 or more pounds in one week. On 8/26/25 at 3:52 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-N and CNA-O who indicated the nurse provides a list of residents with daily weights. After obtaining a resident's weight, CNA-N and CNA-O indicated they update the nurse and the nurse updates the doctor. CNA-N and CNA-O indicated if a resident's weight is off by an abnormal amount, they re-weigh the resident. On 8/26/25 at 4:00 PM, Surveyor interviewed Registered Nurse (RN)-L who indicated the facility has a daily weight list and the provider should be updated if a resident gains 3 or more pounds in 24 hours. On 8/26/25 at 4:24 PM, Surveyor and RN-M reviewed R65 and R52's weights. RN-M confirmed R65 and R52 had weight changes that met the physician's order of 3 or more pounds within 24 hours and 5 or more pounds within one week. RN-M confirmed the weight changes should have been communicated to the provider. RN-M reviewed progress notes for R65 and R52 and confirmed R65 and R52's medical records did not indicate the provider was notified of the weight changes. RN-M indicated the facility did not have a formal daily weight list and indicated the nurse writes a daily list per residents' daily weight orders. On 8/27/25 at 8:31 AM, Surveyor interviewed Infection Preventionist (IP)-D regarding R65 and R52's weight gains. IP-D confirmed R65 and R52's medical records did not indicate the provider was updated regarding R65 and R52's weight gains and confirmed the provider should have been updated per R65 and R52's orders. IP-D indicated the facility recognized daily weights were an issue in February 2025 and had a plan of correction with audits until June 2025. IP-D indicated the facility recognized the same issue again on 8/25/25 and started another plan of correction with education. Nursing Home Administrator (NHA)-A indicated the plan of correction was started at approximately 12:00 PM on 8/25/25 (which was after the survey team had entered). IP-D also indicated R65's 33 pound weight gain should have triggered a re-weigh and a progress note should have been entered. IP-D indicated if the re-weight did not change, the provider should have been updated. 3. From 8/25/25 to 8/27/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including CHF, hypertension, chronic kidney disease, and diabetes. R9's MDS assessment, dated 7/25/25, had a BIMS score of 10 out of 15 which indicated R9 had moderate cognitive impairment. R9's care plan, revised 7/25/25, indicated R9 had congestive heart failure and contained interventions to monitor and report signs of congestive heart failure such as edema, crackles/wheezes, weakness, and weight gain unrelated to intake. R9's physician's orders, dated 4/18/25, indicated: ~ Weights on Monday, Wednesday, and Friday related to heart failure as directed by provider. Call for weight gain of 3 pounds or greater in 24 hours or 5 pounds in one week. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Update provider with any signs/symptoms of worsening CHF. A weight change progress note, dated 7/11/25, indicated R9 weighed 177 pounds and had a 13 pound (7. 9%) weight gain in 3 months and a 17 pound (10.6%) weight gain in 6 months. The note stated R9's weight showed an upward trend with a history of CHF. An update to the provider was requested. R9's medical record did not indicate the provider was notified of R9's significant weight gain. R9's medical record contained the following weights: ~ On 8/6/25, R9 weighed 171 pounds. ~ On 8/15/25, R9 weighed 180.3 pounds (which was a 9.3 pound gain). Suveyor noted R9's medical record did not indicate the provider was notified when R9 gained over 5 pounds in one week. On 8/27/25 at 11:09 AM, Surveyor interviewed Director of Nursing (DON)-B who verified the provider should be notified of a significant weight gain within 24 to 48 hours of identification or as otherwise ordered. DON-B could not verify that R9's provider was updated within 24 to 48 hours of identifying R9's significant weight gain.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview and record review, the facility did not designate a person to serve as the director of food and nutrition services who was a certified dietary manager, a certified food service manager, had a national certification for food service management and safety from a national certifying body, or who had an associate's or higher level degree in food service management or hospitality. This practice had the potential to affect all 70 residents residing in the facility. Findings include:On 8/26/25, Surveyor requested to review Dietary Manager (DM)-R's certification. On 8/26/25 at approximately 1:00 PM, Surveyor received paperwork from Nursing Home Administrator (NHA)-A that included a screenshot of test results for DM-R. The paperwork for DM-R indicated DM-R did not pass the dietary manager certification test and was not certified. Surveyor interviewed NHA-A who indicated DM-R did not pass the test and was not able to take the test again for 90 days. NHA-A was unsure when DM-R failed the test. On 8/26/25 at 2:18 PM, Surveyor interviewed NHA-A who indicated NHA-A had not filed a waiver with the State Agency (SA) for the dietary manager position. NHA-A was aware DM-R needed to complete the dietary manager certification because it was discussed with the facility during the facility's last recertification survey.On 8/26/25 at 2:33 PM, Surveyor interviewed DM-R who indicated DM-R failed the test on 7/21/25 and was going to re-take the test when eligible. DM-R indicated DM-R did not have a food service manager certification and/or food service management or hospitality associate's degree. On 8/26/25 at 2:34 PM, Surveyor interviewed RD-Q who was aware DM-R did not have the required certification and did not pass the dietary manager certification test. RD-Q indicated RD-Q did not work full time at the facility but was actively working with DM-R to study for the next test.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 3 residents (R2, R3, and R59) of 11 sampled residents.R2 was on isolation precautions for Clostridium Difficile (C. diff). During observations of care, staff did not don the appropriate personal protective equipment (PPE) and complete hand hygiene prior to entering and exiting R2's room and did not dispose of soiled linens in accordance with the facility's policy. In addition, R2's Kardex (an abbreviated care plan used by nursing staff) did not indicate R2 was on isolation precautions and R2's medical record did not contain Clostridium Difficile as a diagnosis.Staff did not don the appropriate PPE while completing a dressing change and nephrostomy tube care for R3.R59 had a wound. Enhanced barrier precautions (EBP) were not initiated in a timely manner. In addition, staff did not adhere to EBP during high- contact cares for R59. Findings include:The facility's policy titled Policy & Procedure Enhanced Barrier Precautions, dated 3/26/24, indicates: Enhanced barrier precautions (EBP) require gown and glove use for residents with a novel or targeted multidrug-resistant organism (MDRO) or any resident with a wound or indwelling medical device during specific high-contact resident care activities. High-contact resident care activities include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device; central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing.The facility's policy titled Policy & Procedure Isolation Precautions, revised 5/8/24, indicates: Purpose: To establish transmission-based precautions for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others . 2. Post clear signage on the door or wall outside the resident's room indicating the type of precautions and required PPE .Contact precautions: 1. Implemented for residents suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces/equipment in the resident's environment .3. Prior to entering an isolation room, the following steps are required: a. Perform hand-hygiene and apply gloves and gown prior to entering room; b. While providing direct resident care, wear gloves and wash hands after coming in contact with infectious material; c. Remove gloves and perform hand hygiene before leaving room. (Do not use alcohol-based hand gels for isolation due to suspected or confirmed Clostridium Difficile and Norovirus); d. Adequately clean/disinfect items with an approved solution prior to removing the item from the room and before use on another resident.The facility's policy titled Policy & Procedure Clostridium Difficile, revised 5/8/24, indicates: Purpose: To provide guidelines for the care of persons with Clostridium difficile (C. diff) verified by culture or by evidence of positive cytotoxin, essay, and to prevent transmission of C. diff to others . Residents with diarrhea-associated C. diff will be placed on contact precautions .5. All physically contaminated articles must be considered potentially infectious. C. diff is spore forming, and if not well contained, all surfaces in a resident's room must be considered potentially contaminated. 6. Steps toward prevention and early intervention include: .c. Hand washing of staff and residents; d. Wearing gloves and gowns (if necessary) when handling feces or fecal contaminated articles .7. All equipment in the resident's room must be considered potentially contaminated by C. diff spores .9. Observe proper hand hygiene procedures by washing hands with conventional antiseptic-containing soap and water. Alcohol-based hand sanitizers are not effective on C. diff.1.From 8/25/25 to 8/27/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, neuromuscular dysfunction of bladder, neurogenic bowel, and extended-spectrum beta lactamase resistance (ESBL). R2's Minimum Data Set (MDS) assessment, dated 7/20/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R2 had severely impaired cognition. R2 had an activated Power of Attorney for Healthcare (POAHC). R2's care plan indicated: Isolation Precautions: Contact precautions initiated on 7/30/25. R2's Kardex indicated R2 was on EBP.PCR tests, dated 2/19/25 and 7/29/25, indicated R2 was positive for Clostridium difficile glutamate dehydrogenase (gdh) enzyme and toxin. R2 had a physician order, dated 7/30/25, for Vancomycin HCl oral capsule 125 milligrams (mg) Give 1 capsule by mouth every 6 hours for Clostridium difficile for 14 days; Give 1 capsule by mouth two times a day for Clostridium difficile for 7 days; Give 1 capsule by mouth one time a day for Clostridium difficile for 7 days (end date 8/29/25). A diagnosis of enterocolitis due to Clostridium difficile, recurrent was added to R2's diagnosis list on 8/27/25