STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525299	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDENBROOK OF OSHKOSH	1850 BOWEN ST OSHKOSH, WI 54901

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews, oncology staff interview, and record review, the facility did not ensure a resident's (R) physician was immediately notified of an acute change in condition for 1 (R1) of 4 sampled residents. The facility did not notify and consult with R1's physician regarding acute changes including increased weakness and low oxygen saturation prior to sending R1 to an oncology appointment. Findings include: On 9/2/2020, Surveyor reviewed R1's medical record which documented R1 was admitted to the facility for rehabilitation therapy to treat generalized weakness R1 experienced in relation to chronic lymphoid [MEDICAL CONDITION] (a type [MEDICAL CONDITION] in blood and bone marrow). R1's physician ordered oxygen be applied as needed to keep oxygen saturation at or above 92% or for comfort. R1 had a scheduled appointment with oncology on 8/26/2020 at 3:00 PM. On 8/26/2020 at 2:37 PM, Trained Medication Assistant (TMA)-C entered an oxygen saturation level of 84%. Surveyor noted R1's medical record did not document application of oxygen or communication with the oncology clinic until R1 returned to facility. R1's record documented R1 was ordered hospice during the oncology visit. On 9/3/2020 at 11:03 AM, Surveyor interviewed TMA-C via telephone regarding R1. TMA-C recalled the events of 8/26/2020 which included being told in report that R1 was going to an appointment and needed to be transferred with a full body sling. TMA-C indicated this was a change from the previous time TMA-C worked with R1 approximately four days earlier because R1 was able to walk to the bathroom with one assistant and a walker at that time. TMA-C recalled taking R1's oxygen saturation level which was low just prior to transport. TMA-C saw a nurse in the hallway when exiting R1's room and immediately passed on the information. On 9/3/2020 at 9:24 AM, Surveyor interviewed Registered Nurse (RN)-D via telephone regarding R1. RN-D verified being the charge nurse on 8/26/2020 and recalled the events of 8/26/2020 which included information passed on in report when RN-D came on shift. RN-D explained that R1 was usually transferred with one to two people with a gait belt but it was suggested that R1 needed to be transferred with a full body lift. RN-D expressed doubt that the previous shift utilized a full lift for R1 because RN-D did not see a lift sling under R1. RN-D indicated R1 was transferred with two assistants and a gait belt and RN-D got vitals because R1 was clammy and lethargic. RN-D verified R1's oxygen was low and indicated RN-D wanted to send R1 to the emergency room (ER) but knew the family was waiting outside the building to provide transport to an oncology appointment. RN-D denied discussing the possibility of sending R1 to the ER with R1, R1's family, or the oncology clinic. During a follow-up phone interview at 1:10 PM, RN-D indicated the usual practice is to call and contact a physician to update on any acute change in condition. RN-D denied contacting a physician in R1's case because R1 was no longer physically in the building and was on the way to a physician appointment. RN-D said, It all happened so fast and indicated there was not a chance to do a full assessment. On 9/3/2020 at 1:23 PM, Surveyor interviewed RN-F via telephone. RN-F verified being the nurse responsible for R1's care the morning of 8/26/2020. RN-F recalled R1 was getting weaker but knew R1 had an appointment on that day. RN-F denied notifying any physician of R1's decline. On 9/3/2020 at 12:31 PM, Surveyor interviewed Aurora Internal Medicine RN-E regarding R1 via telephone. RN-E verified being one of the nurses to assist R1 on 8/26/2020 when R1 arrived for an oncology appointment. RN-E indicated R1 arrived at the appointment in a state of actively dying and could not even hold head upright. RN-E accessed R1's medical record and verified R1 had a low oxygen saturation upon arrival. RN-E indicated the facility did not communicate R1's changes prior to sending R1 to the appointment. On 9/3/2020 at 11:16 AM, Surveyor interviewed Director of Nursing (DON)-B via telephone. DON-B expressed an expectation that a change in condition be assessed and communicated to physicians. Specific to R1, DON-B accessed R1's medical record at the time of interview, verified R1's low oxygen prior to being sent to oncology appointment, and indicated DON-B was not aware of situation until Surveyor interview but would have expected oxygen to be applied and the physician to be notified to determine if R1 should still go to the appointment, the ER, or stay at the facility.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on staff interview and record review, the facility did not ensure an allegation of neglect was thoroughly investigated for 1 Resident (R) (R4) of 1 residents with an allegation of neglect. The facility did not document an investigation into R4's allegation that staff neglected responding to R4's call light for toileting assistance for over an hour. Findings include: On 9/4/2020, Surveyor reviewed the facility complaint file which contained a grievance form, dated 4/2/2020, documenting R4 alleged being neglected for more than an hour after activating a call light for assistance with toileting around 1:15 PM. R4's grievance form documented R4 alleged seeing staff answer the a call light across the hall and staff walking past R4's room. R4 named two staff members responsible for care during the allegation's timeframe and was documented as stating It's not right that I have to wait this long and I'm sure I'm not the only one. Surveyor noted there were no staff or resident interviews to determine if the allegation occurred. The grievance form's follow-up and resolution areas were not completed or signed-off by staff. On 9/4/2020 at 10:13 AM, Social Worker (SW)-G verified there was no additional paperwork located with the grievance form. SW-G explained a different SW was employed by the facility at the time the grievance form was completed. On 9/4/2020 at 10:30 AM, Nursing Home Administrator (NHA)-A indicated the facility ran call light audits from 4/4/2020 through 4/6/2020 on the AM and PM shifts. NHA-A verified no interviews were located as part of the investigation and Director of Nursing (DON)-B indicated the facility placed calls to staff involved to determine if interviews were completed at the time and gather statements.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interviews, oncology clinic staff interview, and record review, the facility did not ensure oxygen was applied as needed per physician orders [REDACTED]. R1's physician order [REDACTED]. Findings include: On 9/2/2020, Surveyor reviewed R1's medical record which documented R1 was admitted to the facility for rehabilitation therapy to treat generalized weakness R1 experienced in relation to chronic lymphoid [MEDICAL CONDITION] (a type [MEDICAL CONDITION] in blood and bone marrow). R1's physician order, dated 8/20/2020, indicated oxygen be applied as needed to keep oxygen saturation at or above 92% or for comfort. R1 had a scheduled appointment with oncology on 8/26/2020 at 3:00 PM. On 8/26/2020 at 2:37 PM, Trained Medication Assistant (TMA)-C entered an oxygen saturation level of 84%. Surveyor noted R1's medical record did not document application of oxygen or communication with the oncology clinic until R1 returned to facility (See F580 for notification concerns). On 9/3/2020 at 11:03 AM, Surveyor interviewed TMA-C via telephone regarding R1. TMA-C recalled taking R1's oxygen saturation level which was low on 8/26/2020 just prior to R1's transport for oncology appointment. TMA-C saw a nurse in the hallway when exiting R1's room and immediately passed on the information. TMA-C denies applying oxygen for R1. On 9/3/2020 at 9:24 AM, Surveyor interviewed Registered Nurse (RN)-D via telephone regarding

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) R1. RN-D verified being the charge nurse on 8/26/2020 and recalled the events of 8/26/2020 which included taking R1's vitals because R1 was clammy and lethargic. RN-D verified R1's oxygen was low. RN-D denied applying oxygen to R1 prior to sending R1 to the oncology appointment. On 9/3/2020 at 12:31 PM, Surveyor interviewed Aurora Internal Medicine RN-E regarding R1 via telephone. RN-E verified being one of the nurses to assist R1 on 8/26/2020 when R1 arrived for an oncology appointment. RN-E indicated R1 arrived at the appointment in a state of actively dying and could not even hold head upright. RN-E accessed R1's medical record and verified R1 had a low (79%) oxygen saturation upon arrival. On 9/3/2020 at 11:16 AM, Surveyor interviewed Director of Nursing (DON)-B via telephone. DON-B expressed an expectation that oxygen be applied for residents with low oxygen saturation and explained Wisconsin allows oxygen to be applied for a short time without an order. DON-B accessed R1's medical record at the time of interview, verified R1's low (84%) oxygen saturation prior to being sent to oncology appointment, and indicated DON-B was not aware of situation until Surveyor interview but would have expected oxygen to be applied at the time of low oxygen saturation.