STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a baseline care plan was developed and implemented within 48 hours of a resident's admission for 1 (R1) of 1 resident. R1's baseline Activities of Daily Living (ADL) care plan was not completed within the required 48 hours timeframe. The facility did not provide evidence that the baseline care plan was reviewed with R1. Findings include: R1 was admitted to the facility on [DATE]. R1 was hospitalized [DATE] - 1/9/26 due to left cerebellar intracranial hemorrhage (a critical life-threatening medical emergency involving bleeding inside the skull which can rapidly destroy brain cells by causing pressure and oxygen deprivation). R1's diagnoses include intracranial hemorrhage, dysphagia (difficulty swallowing), morbid obesity, atrial fibrillation (irregular heart rate), heart disease, transient ischemic attack (TIA) (temporary blockage of blood flow to the brain), and cognitive impairment (decline in mental abilities). R1's admission Minimum Data Set (MDS) completed on 1/21/26, documents R1 uses a walker and manual wheelchair. R1 requires substantial/maximal assistance with bathing, dressing, and rolling left to right. R1 is dependent on staff for toileting hygiene. R1 was documented as having a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1's care plan, dated 1/9/26, documents the following:Hypertension (date initiated 1/9/26).Interventions include:Evaluate blood pressure (date initiated 1/9/26). Arrhythmia (date initiated 1/9/26).Interventions include:Evaluate heart rate character, rhythm (date initiated 1/9/26).Evaluate pedal pulses (date initiated 1/9/26). R1 is at risk for bleeding (date initiated 1/9/26)Goals include:R1 will be free of falls (date initiated 1/14/26).R1 will show no signs/symptoms of bleeding (date initiated 1/9/26).Interventions include:Evaluate blood pressure (date initiated 1/14/26).Evaluate fall risk on admission and as needed (date initiated 1/9/26).Evaluate for change in level of consciousness (date initiated 1/9/26).If a fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol (date initiated 1/9/26).Monitor laboratory results (date initiated 1/9/26). Risk for decreased cardiac output (date initiated 1/9/26).Interventions include:Evaluate for change in level of consciousness (date initiated 1/9/26).Evaluate skin color, temperature and moisture (date initiated 1/9/26). Altered neurological status (date initiated 1/14/26).Goals include:R1's skin will remain intact (date initiated 1/14/26).Interventions include:Evaluate skin for areas of blanching or redness (date initiated 1/14/26).Utilize pressure relieving devices on appropriate surfaces (date initiated 1/14/26). R1 uses a safety device wheelchair for mobility related to impaired ambulation (date initiated 1/29/26).Interventions include:A safety device review will be completed upon implementation of a device, annually and with any major change in condition (date initiated 1/29/26).An annual consent reviewing the risks and benefits of the device will be reviewed and signed by myself or my responsible party (date initiated 1/29/26).Once the device is implemented, staff will review and document for three days if any signs of physical or mental distress are present (date initiated 1/29/26). R1 has dehydration or potential fluid deficit (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(date initiated 1/22/26).Interventions include:Administer medications as ordered. Monitor/document for side effects and effectiveness (date initiated 1/22/26).Monitor vital signs as ordered/per protocol and record. Notify Medical Director (MD) of significant abnormalities (date initiated 1/22/26).Notify Physician if: persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours; persistent output exceeding intake past 48 hours; abnormal lab (date initiated 1/22/26).Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated (date initiated 1/22/26). R1 is on a No Added Salt (NAS) diet for: congestive heart failure and hypertension (date initiated 1/23/26).Interventions include:Educate R1 on no added salt diet choices and purpose for restriction (date initiated 1/23/26).Encourage no added salt food choices. Praise efforts at diet compliance (date initiated 1/23/26).Notify nurse of noncompliance with no added salt diet (date initiated 1/23/26).Perform lab tests as ordered and notify Physician of results (date initiated 1/23/26).Provide R1 a no added salt diet. Offer R1 sodium free seasonings (date initiated 1/23/26).Referral to dietitian as needed for additional education or support (date initiated 1/23/26). R1 has impaired physical mobility (date Initiated 1/14/26).Interventions include:Evaluate skin for areas of blanching or redness (date initiated 1/14/26).Utilize pressure relieving devices on appropriate surfaces (date initiated 1/14/26). Surveyor notes R1's baseline care plan does not document R1's Activities of Daily Living (ADL)s needs indicating if R1 requires assistance with toileting, dressing, eating, transfers, bathing, and personal cares.Surveyor notes R1's Care Plan documents R1 has impaired mobility requiring a wheelchair dated 1/29/26 (20 days after admission). R1's mobility needs were not addressed in R1's baseline care plan. Surveyor reviewed R1's Electronic Medical Record (EMR) and did not find evidence the baseline care plan summary was provided to R1. Surveyor reviewed R1's orders and notes the following:-Polyethylene Glycol 3350 Powder. Give 17 gram by mouth in the morning for constipation (ordered on 1/10/26, at 8:00 AM).-Trazadone 150 mg tablet. Give 75 mg (0.5 tablet) by mouth at bedtime for depression (ordered on 1/9/26, at 8:00 PM).-Eliquis 5 mg tablet. Give one tablet by mouth two times a day for atrial fibrillation (irregular heartbeat), (ordered on 1/29/26, at 8:00 PM).-Sennosides tablet 8.6 mg. Give two tablets by mouth two times a day for constipation (ordered on 1/9/26, at 8:00 PM).Surveyor notes R1's baseline Care Plan does not include R1's concerns for depression, taking an anticoagulant, and constipation. On 2/4/26, at 9:42 AM, Surveyor interviewed R1 who states the facility staff have not reviewed care plan interventions or provided a copy of the care plan to R1. On 2/5/26, at 3:17 PM, Surveyor interviewed Director of Nursing (DON)-B about baseline care plans. DON-B states the admitting nurse completes assessments and creates a temporary care plan that includes skin and falls. DON-B the stated the Minimum Data Set (MDS) staff start and create baseline care plans on admission assessments. MDS staff will also include care plans for nursing responsibilities and therapy department will put in care plans that are appropriate for therapy. DON-B states the Interdisciplinary Team (IDT) reviews care plans and signs off on the care plans. DON-B indicates the MDS Coordinator is no longer at the facility and there is another MDS Coordinator that is off site helping remotely. DON-B states the regional nurses will also help with baseline care plans. On 2/9/26, at 3:12 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Regional Nurse-D of concerns R1's baseline care plan concerns listed above. There is no evidence R1 was provided with a written summary of R1's baseline care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop and implement a comprehensive person-centered care plan for 9 (R1, R3, R5, R6, R7, R8, R9, R11, R12) of 13 residents reviewed to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. *R1 has Atrial Fibrillation (A-Fib) and receives anticoagulant therapy. R1 has history of Intracranial Hemorrhage and hypertension and receives Amlodipine, Carvedilol, Lisinopril, and Hydrochlorothiazide for hypertension. R1 does not have a comprehensive care plan that addresses anticoagulant or blood pressure management. R1's goals for altered neurological status and impaired physical mobility do not reflect appropriate goals. *R3 was assessed to be at risk for pressure injury. Facility staff did not document the start of a skin integrity/pressure injury care plan until 10 weeks after admission. When a skin integrity care plan was placed, it did not include interventions on how often R3 should be turned and repositioned. Facility staff documented R3 had an indwelling catheter. An indwelling catheter care plan was not placed until 6 months later. R3 is incontinent of bowel. R3's bowel incontinence care plan does not include an intervention of how often R3 should be checked & changed for bowel incontinence. *R5 is always incontinent of bowel and bladder. R5's bladder incontinence and bowel incontinence care plans do not include an intervention as to how often R5 should be checked and changed. *R6 is dependent on staff for rolling left and right and is always incontinent of bowel and bladder. R6's bladder incontinence care plan does not include an intervention of how often R6 should be checked and changed. There is not a care plan for R6's bowel incontinence. R6's Activities of Daily Living (ADL) care plan does not include an intervention for bed mobility. *R7 is dependent on staff for rolling left and right and is incontinent of bowel and bladder. R7's bowel incontinence and bladder incontinence care plan does not include an intervention of how often R7 should be checked and changed. R7's ADL self-care deficit care plan does not include an intervention of how often R7 should be repositioned. *R8 is dependent on staff for rolling left and right. R8's ADL self-care performance deficit care plan for bed mobility does not include an intervention of how often R8 should be repositioned. *R9 is always incontinent of bowel and is dependent on staff for rolling left and right. R9's bowel incontinence care plan and ADL self-care performance deficit care plans do not include interventions of how often R9 should be checked and changed for bowel incontinence and how often R9 should be repositioned. *R11 is dependent on staff for rolling left and right and is always incontinent of bowel. R11's bowel incontinence care plan does not include an intervention of how often R11 should be checked and changed. R11's ADL care plan for bed mobility does not include how often R11 should be repositioned. *R12 is dependent on staff for rolling left and right and is always incontinent of bowel and bladder. R12's bowel incontinence and bladder incontinence care plan does not include an intervention of how often R12 should be checked and changed. R12's ADL care plan for bed mobility has an intervention (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to reposition as necessary. The care plan does not indicate how often R12 should be repositioned. Findings include: The facility's police titled Care Plans, Comprehensive Person-Centered, that is not dated, documents: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required Minimum Data Set (MDS) assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan: *Includes measurable objectives and timeframes. *Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: **Services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. **Which professional services are responsible for each element of care. Includes the resident's stated goals upon admission and desired outcomes. Builds on the residents' strengths; and Reflects currently recognized standards of practice for problem areas and conditions. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. The interdisciplinary team reviews and updates the care plan: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*When there has been a significant change in the residents' condition. *When the desired outcome is not met. *When the resident has been readmitted to the facility from a hospital stay; and *At least quarterly, in conjunction with the required quarterly MDS assessment. 1.) R1 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R1 was hospitalized [DATE] – 1/9/26 due to left cerebellar intracranial hemorrhage (a critical life-threatening medical emergency involving bleeding inside the skull which can rapidly destroy brain cells by causing pressure and oxygen deprivation). R1's diagnoses include intracranial hemorrhage, dysphagia (difficulty swallowing), morbid obesity, atrial fibrillation (irregular heart rate), heart disease, transient ischemic attack (TIA) (temporary blockage of blood flow to the brain), and cognitive impairment (decline in mental abilities). R1's admission Minimum Data Set (MDS) completed on 1/21/26, documents that R1 uses a walker and manual wheelchair. R1 requires substantial/maximal assistance with bathing, dressing, and rolling left to right. R1 is dependent on staff for toileting hygiene. R1 was documented as having a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1's care plan, dated 1/9/26, documents the following: Hypertension (date initiated 1/9/26). Interventions include: Evaluate blood pressure (date initiated 1/9/26). Arrhythmia (date initiated 1/9/26). Interventions include: Evaluate heart rate character, rhythm (date initiated 1/9/26). Evaluate pedal pulses (date initiated 1/9/26). R1 is at risk for bleeding (date initiated 1/9/26) Goals include: R1 will be free of falls (date initiated 1/14/26). R1 will show no signs/symptoms of bleeding (date initiated 1/9/26). Interventions include: Evaluate blood pressure (date initiated 1/14/26). Evaluate fall risk on admission and as needed (date initiated 1/9/26). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evaluate for change in level of consciousness (date initiated 1/9/26). If a fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol (date initiated 1/9/26). Monitor laboratory results (date initiated 1/9/26). Risk for decreased cardiac output (date initiated 1/9/26). Interventions include: Evaluate for change in level of consciousness (date initiated 1/9/26). Evaluate skin color, temperature and moisture (date initiated 1/9/26). Altered neurological status (date initiated 1/14/26). Goals include: R1's skin will remain intact (date initiated 1/14/26). Interventions include: Evaluate skin for areas of blanching or redness (date initiated 1/14/26). Utilize pressure relieving devices on appropriate surfaces (date initiated 1/14/26). R1 uses a safety device wheelchair for mobility related to impaired ambulation (date initiated 1/29/26). Interventions include: A safety device review will be completed upon implementation of a device, annually and with any major change in condition (date initiated 1/29/26). An annual consent reviewing the risks and benefits of the device will be reviewed and signed by myself or my responsible party (date initiated 1/29/26). Once the device is implemented, staff will review and document for three days if any signs of physical or mental distress are present (date initiated 1/29/26). R1 has dehydration or potential fluid deficit (date initiated 1/22/26). Interventions include: Administer medications as ordered. Monitor/document for side effects and effectiveness (date initiated 1/22/26). Monitor vital signs as ordered/per protocol and record. Notify Medical Director (MD) of significant (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abnormalities (date initiated 1/22/26). Notify Physician if: persistent symptoms of diarrhea, nausea/vomiting unresolved past 48 hours; persistent output exceeding intake past 48 hours; abnormal lab (date initiated 1/22/26). Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated (date initiated 1/22/26). R1 is on a No Added Salt (NAS) diet for: congestive heart failure and hypertension (date initiated 1/23/26). Interventions include: Educate R1 on no added salt diet choices and purpose for restriction (date initiated 1/23/26). Encourage no added salt food choices. Praise efforts at diet compliance (date initiated 1/23/26). Notify nurse of noncompliance with no added salt diet (date initiated 1/23/26). Perform lab tests as ordered and notify Physician of results (date initiated 1/23/26). Provide R1 a no added salt diet. Offer R1 sodium free seasonings (date initiated 1/23/26). Referral to dietitian as needed for additional education or support (date initiated 1/23/26). R1 has impaired physical mobility (date Initiated 1/14/26). Interventions include: Evaluate skin for areas of blanching or redness (date initiated 1/14/26). Utilize pressure relieving devices on appropriate surfaces (date initiated 1/14/26). Surveyor reviewed R1's orders and notes the following: Amlodipine 10 mg by mouth once daily for hypertension (high blood pressure) (ordered on 1/10/26, at 8:00 AM). Carvedilol 25 mg tablet. Give one tablet by mouth two times a day for hypertension (ordered on 1/9/26, at 8:00 PM). Eliquis 5 mg tablet. Give one tablet by mouth two times a day for atrial fibrillation (irregular heartbeat), (ordered on 1/29/26, at 8:00 PM). Lisinopril 20 mg tablet. Give one tablet by mouth every morning and at bedtime for hypertension (ordered on 1/9/26, at 8:00 PM). Check Blood Pressure and Heart Rate (BP/HR) three times daily at every shift due to recent Intracerebral Hemorrhage (ICH) (stroke) (ordered on 1/15/26, at 2:00 PM). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydralazine 25 mg tablet. Give 25 mg by mouth every 8 hours as needed for Systolic Blood Pressure (SBP) > 175 (ordered on 1/9/26, at 6:00 PM, discontinued on 1/14/26, at 10:15 AM). Hydralazine 25 mg tablet. Give one tablet by mouth every 8 hours for hypertension. Hold for SBP less than 130 (ordered on 1/14/26, at 4:00 PM, discontinued on 1/29/26, at 6:31 AM). Hydralazine 25 mg tablet. Given 1 tablet by mouth every 8 hours as needed for SBP 175 or greater (ordered on 1/29/26, at 6:45 AM). Surveyor notes R1 is taking Blood Pressure medication and an Anticoagulant (Eliquis). R1's care plan does not monitor the effectiveness and possible side effects of blood pressure medications and Anticoagulant. Surveyor notes R1's altered neurological status care plan goal, documents skin will remain intact and do not reflect R1's goals for altered neurological status. Surveyor notes R1's impaired physical mobility care plan goal, documents staff to evaluate skin and utilize pressure relieving devices and does not reflect R1's goals for impaired physical mobility. On 2/4/26, at 9:42 AM, Surveyor interviewed R1 who states facility staff have not reviewed care plan or care plan interventions with R1. On 2/5/26, at 3:17 PM, Surveyor interviewed Director of Nursing (DON)-B about care plans. DON-B states the admitting nurse completes assessments and creates a temporary care plan that includes skin and falls. DON-B then stated the Minimum Data Set (MDS) staff start and create baseline care plans on admission assessments. MDS staff will also include care plans for nursing responsibilities, and the therapy department will put in care plans that are appropriate for therapy. DON-B states the Interdisciplinary Team (IDT) reviews care plans and signs off on resident care plans. DON-B indicates the MDS Coordinator is no longer at the facility and there is another MDS Coordinator that is off site helping remotely. DON-B states the regional nurses will also help with care plans. On 2/9/26, at 3:12 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Regional Nurse-D of concerns listed above with R1's comprehensive care plan. NHA-A and Regional Nurse-D acknowledged these concerns. 2.) R3 was admitted to the facility on [DATE] with diagnosis that include Cardiac arrest in 11/2024 which led to an anoxic brain injury (Brain deprived of oxygen causing cell death within minutes). Chronic respiratory failure (Long term condition where the lungs can't properly oxygenate blood or remove carbon dioxide), Chronic obstructive pulmonary disease (Progressive, incurable lung disease). Tracheostomy (A device in the neck that goes into the windpipe to provide an alternative airway), Ventilator-Dependent (Patient is unable to breathe independently for extended periods, requiring mechanical ventilation), Gastrostomy tube (Device inserted through the abdomen directly into the stomach to provide long-term nutrition) and Hypotension (Low blood pressure). R3's admission Minimum Data Set (MDS) assessment dated [DATE] documents R3 is severely cognitively impaired. R3 is always incontinent of bladder and frequently incontinent of bowel. R3 is dependent on facility staff for all cares, mobility and transfers. R3 is at risk for pressure injuries but does not have a current pressure injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Certified Nursing Assistant (CNA) Kardex/Care Plan as of 2/4/26 documents, in part: Under Resident Care is listed pertinent interventions of [Alternating Pressure Mattress], Prevalon boots, Repositioning pillows to protect the skin while in bed. Use a draw sheet or lifting device to move resident. Under Bladder/Bowel is listed interventions of Monitor [signs and symptoms] of catheter complication i.e. leaking, obstruction, etc. Urinary Continence- [as needed]. Under bed mobility is listed Bowel Continence. Under Mobility is pertinent intervention of Broda Chair. R3's Potential/actual impairment to skin integrity care plan initiated on 4/4/25 documents the following interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Implement pressure-reducing devices i.e. w/c cushion, air-mattress, off-loading heels, etc. Provide pressure relieving device: [Alternating Pressure Mattress], Prevalon boots, repositioning pillow. Use a draw sheet or lifting device to move resident. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Surveyor noted R3 was admitted to the facility and was assessed, upon admission, to be at risk for pressure injuries and dependent for mobility. Surveyor noted a skin integrity or pressure injury care plan was not initiated until 4/4/25, 10 weeks after admission. R3's Discharge Return Anticipated MDS assessment dated [DATE] documents R3 has an indwelling catheter. R3 is always incontinent of bowel. R3 has an unhealed unstageable pressure injury. On 4/19/25, R3's MDS documents R3 has a current pressure injury. Surveyor noted R3's CNA Kardex and Comprehensive Care plan does not list the level of assistance needed for R3's bed mobility and does not include an intervention of how often R3 should be turned and repositioned which could impact the healing of the pressure injury. Surveyor reviewed R3's Comprehensive Care Plan and noted R3 does not have an Activities of Daily Living Care plan documenting R3's transfer status or R3's bed mobility status. On 4/19/25, R3's MDS documented R3 as having an indwelling catheter. R3's Urinary Catheter care plan initiated 10/28/25, documents the following pertinent interventions: Monitor and document intake and output as per facility policy. Monitor for [signs and symptoms] of catheter complications. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for [signs and symptoms] [Urinary tract infection] . Surveyor noted R3's Catheter was documented as being in place on 4/19/25. A care plan for R3's catheter was not put in place until 10/28/25, 6 months after the catheter was placed. On 4/19/24, R3's MDS documented R3 is always incontinent of bowel. R3's Bowel incontinence care plan initiated 4/7/25 documents the following interventions: Provide peri care after each incontinent episode. Staff will apply barrier cream as needed after incontinence care. Staff will monitor skin for redness or excoriation when providing incontinence care. Surveyor noted R3's bowel incontinence care plan and CNA Kardex does not include an intervention of how often R3 should be checked & changed for bowel incontinence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/9/26 at 8:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-L. Surveyor asked where CNA-L would find information on how to care for a resident. CNA-L stated CNA-L would look at the CNA Kardex. CNA-L stated CNA-L would look at the Kardex every morning to see if anything changed. On 2/9/26, at 2:20 p.m., Surveyor asked Assistant Director of Nursing (ADON)-C to explain the facility's care plan process and how they assure resident care plans are person centered. ADON-C informed Surveyor care plans are individualized at the time of admission. They are updated or revised when there is a change up or down. Surveyor asked who is responsible for updating care plans. ADON-C replied to the nurses. Surveyor asked ADON-C if she was referring to the nurses on the floor. ADON-C replied correct. ADON-C explained that management updates the care plan after admission to ensure care plans are done, edited and revised. On 2/5/26, at 3:17 PM, Surveyor interviewed Director of Nursing (DON)-B about care plans. DON-B states the admitting nurse completes assessments and creates a temporary care plan that includes skin and falls. DON-B then stated the Minimum Data Set (MDS) staff start and create baseline care plans on admission assessments. MDS staff will also include care plans for nursing responsibilities, and the therapy department will put in care plans that are appropriate for therapy. DON-B states the Interdisciplinary Team (IDT) reviews care plans and signs off on resident care plans. DON-B indicates the MDS Coordinator is no longer at the facility and there is another MDS Coordinator that is off site helping remotely. DON-B states the regional nurses will also help with care plans. On 2/10/26, at the exit meeting, Surveyor informed Nursing Home Administrator (NHA)-A of the concerns related to R3's comprehensive care plan. 3.) R5's diagnoses include anoxic brain damage (brain is deprived of oxygen leading to cell death), dysphagia (difficulty swallowing), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), and quadriplegia (paralysis of all four limbs). R5 has a feeding tube and tracheostomy. R5's quarterly MDS (minimum data set) with an assessment reference date of 11/21/25 assesses R5 as having short term & long-term memory problems and is severely impaired for cognitive skills for daily decision making. R5 is dependent on staff for eating, toilet hygiene, roll left and right, and chair/bed to chair transfers. Indwelling catheter is yes and R5 is always incontinent of bowel. Surveyor notes R5's foley catheter was discontinued on 10/25/25. R5's Certified Nursing Assistant (CNA) care card dated 2/5/26 under the section Bladder/Bowel documents *Urinary Continence-PRN (as needed). R5 has bladder incontinence, anoxic brain injury care plan initiated & revised 4/19/25 documents the following interventions *Clean peri-area with each incontinence episode initiated & revised 4/19/25. *Provide loose fitting, easy to remove clothing. Initiated & revised 4/19/25. *Staff will assist with incontinence care as needed. Initiated & revised 4/19/25. *Staff will monitor skin for redness or excoriation when providing incontinence care. Initiated & revised 4/19/25. R5 has bowel incontinence r/t (related to) anoxic brain injury care plan initiated & revised 4/19/25 documents the following interventions *Provide loose fitting, easy to remove clothing. Initiated & revised 4/19/25. *Provide peri care after each incontinent episode. Initiated & revised 4/19/25. *Staff will assist with incontinence care as needed. Initiated and revised 4/19/25. *Staff will (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitor skin for redness or excoriation when providing incontinent care. Initiated & revised 4/19/25. Surveyor noted R5's bladder incontinence and bowel incontinence care plans do not include an intervention as to how often R5 should be checked and changed. 4.) R6's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), dysphagia (difficulty swallowing), anxiety disorder (group of mental health conditions characterized by excessive and persistent worry), and encephalopathy (general brain dysfunction characterized by alteration in brain function or structure). R6 has a gastrostomy tube, tracheostomy and is on a ventilator. R6's admission MDS (minimum data set) with an assessment reference date of 12/25/25 assesses R6 as short- & long-term memory ok and modified independence for cognitive skills for daily decision making. R6 is assessed as being dependent for eating, toileting hygiene, roll left and right and chair/bed to chair transfer. R6 is always incontinent of bowel and bladder. R6's Certified Nursing Assistant Care Plan (CNA) as of 2/5/26 under the section Bladder/Bowel documents *Urinary Continence-PRN (as needed). Under the section Bed Mobility documents *Bowel Continence. R6 has bladder incontinence r/t (related to) impaired mobility care plan initiated & revised 12/29/25 documents the following interventions *Clean peri-area with each incontinence episode. Initiated 12/29/25. *Encourage fluids during the day to promote prompted voiding responses. Initiated 12/29/25. *Establish voiding patterns. Initiated 12/29/25. Surveyor noted R6's bladder incontinence care plan does not include an intervention of how often R6 should be provided incontinence cares. R6 has an ADL (activity daily living) self-care performance deficit disease processes care plan initiated & revised 12/29/25 interventions address bathing/showering, dressing, eating, personal hygiene routine, toilet use, and transfer. The care plan does not include an intervention for how often R6 should be repositioned in bed and/or the Broda chair. Surveyor notes there is not a bowel incontinence care plan. 5.) R7's diagnoses includes myotonic muscular dystrophy (multisystem genetic disorder characterized by progressive muscle wasting, weakness, and delayed relaxation), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide) with hypoxia (low levels of oxygen), dysphagia (difficulty swallowing), and anxiety disorder (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating). R7 has a feeding tube, tracheostomy, and is on a ventilator. R7's quarterly MDS (minimum data set) with an assessment reference date of 1/21/26 assesses R7 as short term & long-term memory as ok and is modified independence for cognitive skills for daily decision making. R7 is assessed for eating as non-applicable. Toileting hygiene, roll left and right is dependent. Chair/bed to chair transfer is assessed as not applicable. Yes, is marked for an indwelling catheter and R7 is always incontinent of bowel. R7's bowel and bladder evaluation dated 1/21/26 for bowel continence always incontinence is checked and urinary continence always incontinence is checked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's foley catheter was discontinued on 1/26/26. R7's Certified Nursing Assistant (CNA) care plan as of 2/5/26 under the section Bladder/Bowel documents *Bowel Movement: record every shift, update nurse with any concerns. *Voiding: record every shift. *Urinary Continence-PRN (as needed). Under the section Bed Mobility documents *Repositioning: ensure proper positioning to promote comfort. *Bowel Continence. R7 has bowel incontinence care plan initiated 4/15/24 and revised 12/14/25 documents the following interventions *Provide bedpan/bedside commode. Initiated & revised 4/15/24. *Provide loose fitting, easy to remove clothing. Initiated & revised 4/15/24. *Provide peri care after each incontinent episode. Initiated & revised 4/15/24. Surveyor noted R7's care plan does not include an intervention for how often R7 should be checked & changed for bowel incontinence. R7 has mixed bladder incontinence care plan initiated 4/15/24 & revised 5/16/24 documents the following interventions *Clean peri-area with each incontinence episode. Initiated & revised 4/15/24. *Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Surveyor noted R7's care plan does not include an intervention of how often R7 should be checked & changed for urinary incontinence. R7's ADL (activities daily living) self-care deficit care plan initiated 4/15/24 & revised 5/30/24 includes an intervention of REPOSITIONING: ensure proper positioning to promote comfort initiated & revised 4/15/24. Surveyor noted R7's ADL self-care deficit care plan does not include an intervention of how often R7 should be repositioned. 6.) R8's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), amyotrophic lateral sclerosis (progressive neurodegenerative disease that destroys motor neurons in the brain and spinal cord leading to severe muscle weakness, paralysis and eventually respiratory failure), dysphagia (difficulty swallowing), and anoxic brain damage (brain is deprived of oxygen leading to cell death). R8 has a feeding tube, tracheostomy, and is on a ventilator. R8's admission MDS (minimum data set) with an assessment reference date of 12/29/25 documents R8 has short- and long-term memory problems and is severely impaired for cognitive skills for daily decision making. R8 is assessed as being dependent for eating, toileting hygiene, roll left and right, and chair/bed to chair transfer. R8 has an indwelling urinary catheter and is always incontinent of bowel. R8's Certified Nursing Assistant care plan as of 2/5/26 under the Bladder/Bowel section documents *Monitor s/s (signs/symptoms) of catheter complications i.e. leaking, obstruction etc. *Urinary Continence-PRN (as needed). Under the section Bed Mobility documents *Bed Mobility: The resident requires TOTAL assistance by 2 staff to turn and reposition in bed and as necessary. *Bowel Continence. *Turn and position as necessary. R8's ADL (activity daily living) self-care performance deficit care plan initiated & revised 10/17/25 includes an intervention *BED MOBILITY: The resident requires TOTAL assistance by 2 staff to turn and reposition in bed and as necessary. Initiated & revised 10/17/25. Surveyor noted R8's ADL self-care performance deficient care plan for bed mobility does not include an intervention of how often (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8 should be repositioned. 7.) R9's diagnoses includes hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting right dominate side, chronic respiratory failure (long term condition where the lungs cannot adequate exchange oxygen and carbon dioxide) with hypoxia (low levels of oxygen), hypertension (high blood pressure) and atrial fibrillation (irregular and rapid heartbeat). R7 has a feeding tube, tracheostomy, and is on a ventilator. R9's admission MDS (minimum data set) with an assessment reference date of 12/30/25 assesses R9 as being comatose. R9 is dependent on eating, toileting hygiene, roll left and right, and chair/bed to chair transfer. R9 has an indwelling urinary catheter and is always incontinent of bowel. R9's Certified Nursing Assistant (CNA) care plan as of 2/5/26 under the Bladder/Bowel section documents *Monitor s/s (signs/symptoms) of catheter complications i.e. leaking, obstruction, etc. *Urinary Continence-PRN (as needed). Under the section Bed Mobility section documents *Bed Mobility: The resident requires assistance by (1) staff to turn and reposition as necessary. *Bowel Continence. *Turn and position as necessary. R9's bowel incontinence care plan initiated 7/31/25 documents an intervention of *Provide peri care after each incontinent episode. Initiated 7/31/25. Surveyor noted R9's bowel incontinence care plan does not include an intervention of how often R9 should be checked and changed. R9's ADL (activity daily living) self-care performance deficit care plan initiated 7/31/25 & revised 8/8/25 documents for BED MOBILITY: The resident requires assistance by (1) staff to turn and reposition in bed as necessary. Initiated 7/31/25 & revised 1/5/26. Surveyor noted R9's care plan does not include an intervention of how often R9 should be repositioned. 8.) R11's diagnoses include chronic respiratory failure (long term condition where the lungs ca

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 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 interview and record review the facility did not ensure 1 (R2) of 1 received the necessary care and treatment for a venous wound. On 1/10/25, the nurses note document R2 developed a wound to the left heel. There is no comprehensive assessment or treatment order for the left heel wound until 1/12/26. There was no baseline care plan related to skin integrity until 1/12/26.Findings include:The facility's Skin Tears-Abrasions and Minor Breaks, Care of policy dated 10/2025 documents:Documentation:Record the following information in the resident's medical record:1. Complete in house investigation of causation2. Generate non pressure form3. Document physician and family notification, and resident education (if completed) in medical record.4. How the resident tolerated the procedure5. Any problems or resident complaints related to the procedure.6. Any complications related to the abrasion (e.g. pain, redness, drainage, swelling, bleeding, decreased movement)7. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risk of refusing the procedure, the benefits of accepting and available alternatives8. Interventions implemented or modified to prevent additional abrasions (e.g. clothes that cover arms and legs).9. When an abrasion/skin tear/bruise is discovered, complete a Report of incident/accident.Reporting:Notify the responsible family member. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma.Notify the physician or any abnormalities (i.e. excessive bleeding, localized swelling, redness, drainage, tenderness, pain, etc.)Report other information in accordance with facility policy/guideline and professional standards of practiceR2 was admitted to the facility on [DATE] with diagnoses of hepatic encephalopathy, alcohol cirrhosis of liver with ascites and pancreatic cancer. The clinical admission assessment dated [DATE] documents no skin issues. The admission minimum data set (MDS) dated [DATE] documents R2 is cognitively intact and needs moderate assistance with bathing, dressing and bed mobility, and is at risk for the development of skin concerns. Surveyor notes R2's MDS does not document any skin concerns. The nurses note dated 1/10/26 documents, R2 received a shower and skin issues were found. A left elbow abrasion skin peeling, right elbow skin peeling, right thumb skin peeling and a left heel open blister. +3 pitting edema to both feet, BLE (bilateral lower extremity) feet elevated with pillow and pressure relief boot applied. All areas cleanse with normal saline followed by xeroform, followed by foam dressing. (The on-call NP) was updated.Surveyor notes this order was not transcribed and was not on R2's Treatment Administration Record (TAR), and a comprehensive assessment of the wounds including skin type and measurements was not completed. Surveyor notes R2's care plan was not revised to include the identification of the new skin issues identified on 1/10/26. The nurses note on 1/12/26 documents Wound Medical Doctor (MD)-R did rounds and assessed R2's wounds. Wound MD-R assessment dated [DATE], documents a venous wound to the left foot measuring 10 by 80 centimeters (cm) with depth unmeasurable due to presence of dried fibrous exudate. It also documents R2 required an increase in the level of care. Recommended oral antibiotics for cellulitis. Spoke to primary. The nurses note dated 1/12/26 documents R2 was sent out to the hospital due to altered mental status. Surveyor requested and was unable to obtain R2's hospital record for the 1/12/26 hospitalization. R2 did not return to the facility. On 2/3/26 at 11:35 a.m., Surveyor interviewed Licensed Practical Nurse (LPN)-N. LPN-N stated Wound MD-R completed wound assessment on 1/12/26. LPN-N stated R2 was confused and not behaving normally even though her vital signs were normal. LNP-N stated something wasn't right with R2, so she was sent out to the hospital. LPN-N stated she only saw the heel wound on 1/12/26.On 2/5/25 at 11:30 a.m., Surveyor interviewed DON-B. Surveyor explained the concern R2 had a wound to the left heel and there wasn't a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive assessment until 1/12/26 and there wasn't any baseline care plan initiated until 1/13/26 after R2 was sent to the hospital. DON-B stated she understands the concern and thinks the nurses were waiting for Wound MD-R to come to the facility to assess the wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1 of 2 residents (R3) reviewed for pressure injuries.R3 was high risk for pressure injuries. R3 developed an unstageable sacral pressure injury (PI) which deteriorated to a stage 4 PI with eventual visible bone. The facility failed to correctly implement and/or enter treatment orders from the hospital and the wound MD and could not provide evidence an ordered CT scan was scheduled or completed. R3 was eventually admitted to the hospital and diagnosed with sepsis and sacral/coccygeal osteomyelitis with abscess requiring debridement and a partial coccygectomy (partial removal of tailbone.) Upon readmission, facility failed to follow wound MD treatment orders. R3 also developed an unstageable PI to the left buttock as well as deep tissue injuries to bilateral heels. Treatment orders were not implemented correctly nor timely. The facility's failure to provide services to promote healing, prevent pressure injury development, and ensure prompt and ordered treatments were implemented created a finding of immediate jeopardy that began on 5/26/25. Surveyor notified the Nursing Home Administrator (NHA)-A of the immediate jeopardy on 2/10/26 at 12:46 PM. The immediate jeopardy was removed on 2/13/2026, however, continues at a scope/severity level of E related to the residents at risk for the development of pressure injuries and as the facility implements its action plan. Findings include: The facility policy titled, Pressure Injuries and Non pressure Injuries, dated 8/2/22, last reviewed 10/21/25, documents, in part: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. Upon admission: A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the admission/readmission evaluation . If skin is compromised. Ensure Primary Care Physician (PCP) is aware of wounds/location of wounds and current treatment orders. Ensure appropriate treatment orders for each wound area, as needed.Initiate the baseline plan of care related to current skin status and skin risk level. (The comprehensive care plan will be developed within seven days of the completion of the comprehensive assessment.) When determining skin risk status and appropriate interventions, consider the following: Braden Scale Score. Co-morbid conditions. Cognitive impairment. Presence of a medical device such as an indwelling catheter, trach. The need or request to elevate the HOB (head of bed). Exposure of skin to urinary and fecal incontinence.Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed).Mobility: As mobility scores decrease, concern about the adequacy of the support surface should increase-evaluate need for specialty [wheelchair] cushion and specialty mattress. Develop turning/repositioning schedule based on resident needs and risk factors. The facility's policy titled, Medication Orders, dated 8/2/22, last reviewed 10/21/25, documents, in part: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Treatment Orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment. The facility's policy titled, Care Plans, Comprehensive Person-Centered, not dated, documents, in part: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	developed and implemented for each resident. Policy Interpretation and Implementation: The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required Minimum Data Set (MDS) assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.The interdisciplinary team reviews and updates the care plan:*When there has been a significant change in the residents' condition;*When the desired outcome is not met;*When the resident has been readmitted to the facility from a hospital stay; and*at least quarterly, in conjunction with the required quarterly MDS assessment. R3 was admitted to the facility on [DATE] with diagnoses to include Cardiac arrest in 11/2024 which led to an anoxic brain injury (Brain deprived of oxygen causing cell death within minutes), Chronic respiratory failure (Long term condition where the lungs can't properly oxygenate blood or remove carbon dioxide), Chronic obstructive pulmonary disease (Progressive, incurable lung disease), Tracheostomy (A device in the neck that goes into the windpipe to provide an alternative airway), Ventilator-Dependent (Patient is unable to breathe independently for extended periods, requiring mechanical ventilation), Gastrostomy tube (Device inserted through the abdomen directly into the stomach to provide long-term nutrition), and Hypotension (Low blood pressure). R3's admission Minimum Data Set Assessment (MDS) dated [DATE] documents R3 is severely cognitively impaired. R3 is always incontinent of bladder and frequently incontinent of bowel. R3 is dependent on facility staff for all cares, mobility, and transfers. R3 is at risk for pressure injuries but does not have a current pressure injury. R3's Pressure injury Care Area assessment dated [DATE] documents, in part: Monitoring and preventative measures in place. R3's Braden scale assessments (an assessment completed to determine how at risk a resident is for developing pressure injuries) completed on 1/20/25 and on 2/21/25 document a score of 11, indicating the resident is at high risk for developing pressure injuries. Surveyor reviewed R3's Care Plan and noted that facility staff did not develop or implement a skin integrity or pressure injury care plan on admission even though R3 was assessed by facility staff to be at high risk for developing pressure injuries. R3 receives continuous enteral nutrition via a g-tube. Surveyor notes R3's head of bed needs to be elevated for the enteral feeds putting R3 at increased risk for the development of pressure injuries. R3 was admitted to the hospital on [DATE]. Surveyor notes R3's discharge MDS dated [DATE] documents R3 does not have an unhealed pressure injury. R3's hospital Discharge summary dated [DATE] documents, in part: Reason for hospitalization: vomiting. Discharge diagnoses: Recurrent [Small bowel obstruction]/ileus. Right arm [Peripherally inserted central catheter] line associated [Deep Vein Thrombosis]. R3 returned to the facility on 4/4/25. Facility entered an MD order for Eliquis (a blood thinning medication) two times a day on 4/4/25 due to a deep vein thrombosis (blood clot) that formed in R3's arm during R3's hospitalization. Surveyor reviewed R3's Care plan and noted facility staff did not implement a care plan for monitoring of R3 while on a blood thinning medication. R3's admission skin assessment dated [DATE] documents, in part: Sacrum. 4.2 [centimeters (cm)] x 3. 100% slough. Wound MD-R updated. New orders Xeroform foam border change daily. R3's MD order with start date of 4/5/25 documents: Sacrum Unstageable: Cleanse with wound cleanser [followed by (f/b)] pat dry f/b skin prep to surrounding peri tissue f/b xeroform to wound bed f/b bordered foam dressing every day shift as needed or if soiled or needs replacement. Surveyor noted the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	treatment order the facility entered for the Sacrum pressure injury was ordered as needed instead of daily as Wound MD-R ordered according to the admission skin assessment note. Surveyor reviewed R3's Treatment Administration Record (TAR) and noted R3's sacral wound treatment was completed on 4/5/26 but there is no documentation that treatment was completed by facility staff on 4/6/25. R3's potential/actual impairment to skin care plan initiated on 4/4/25 documents the following interventions: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Implement pressure-reducing devices i.e. w/c (wheelchair) cushion, air-mattress, off-loading heels, etc., Provide pressure relieving device: [Alternating Pressure Mattress], Prevalon boots, repositioning pillow. Use a draw sheet or lifting device to move resident. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R3's Certified Nursing Assistant (CNA) Kardex as of 2/4/26 documents, in part: Under Resident Care - The resident needs [Alternating Pressure Mattress], Prevalon boots, repositioning pillows to protect the skin while in bed. Use a draw sheet or lifting device to move resident. Under bed Mobility is listed Bowel Continence. Surveyor noted R3's Care plan and CNA Kardex did not include a person-centered intervention regarding a turning and repositioning schedule or off-loading of R3's sacrum. In addition, R3's CNA Kardex listed bowel continence under bed mobility. Surveyor noted no other instructions are listed under bed mobility when R3 is assessed to be completely dependent on staff for mobility. On 4/7/25, Wound MD-R completed wound rounds at the facility. Wound MD-R's Wound evaluation note dated 4/7/25 documents in part: Unstageable (due to necrosis) Sacrum full thickness pressure injury. 4.02 x 2.87 x 0.1. 80% slough (moist, yellowish, tan, green, brown or white tissue that is stringy and mucinous in texture). 20% granulation (new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process).Treatment plan: Xeroform gauze apply once daily. Gauze Island with border. R3's MD order with a start date of 4/8/25, documents: Cleanse with wound cleanser f/b pat dry f/b skin prep to surrounding peri tissue f/b xeroform f/b bordered gauze every day shift for Wound protection/healing. On 4/19/25, R3 became lethargic and was sent to the hospital. R3's hospital Discharge summary dated [DATE], documents, in part: Reason for hospitalization: [R3] . presented to the [Emergency Department] with a chief complaint of lethargy. Discharge diagnoses: Ventilator associated pneumonia.R3 returned to the facility on 4/23/25. R3's admission skin assessment dated [DATE], documents, in part: Coccyx unstageable-bright pink wound bed with slough % and granulation % noted. 7cm in length, 3.5 in width. Treatment is as follows per wound care: Cleanse with wound cleanser f/b pat dry f/b skin prep to surrounding peri-tissue f/b xeroform f/b bordered gauze. Surveyor noted the percentage of slough and granulation was not documented and the same treatment that was in place before this hospitalization was followed upon readmission to the facility. R3's Wound MD-R wound evaluation note dated 4/28/25, documents, in part: Unstageable (Due to necrosis) sacrum full thickness . 5.72 x 2.77 x 0.1. 80% slough. 20% granulation. Treatment plan: Alginate calcium apply once daily and as needed. Gauze Island with border apply once daily. R3's MD order with a start date 4/29/25, documents: Sacrum Unstageable PI: cleanse with wound cleanser f/b pat dry f/b skin prep to surrounding peri-tissue f/b Ca Alginate f/b bordered gauze every day shift for wound protection/healing. On 5/3/25, R3 experienced a change of condition and was sent to the emergency room.R3 returned from the hospital and was readmitted to the facility on [DATE]. R3's Hospital Discharge summary dated [DATE] documents, in part: Reason for admission: Ventilator dependent, Pneumonia of left lower lobe. Final Discharge diagnoses: Acute on chronic respiratory failure hypoxemic on chronic ventilator. Left lower (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	lobe pneumonia likely vent associated pneumonia. Discharge instructions: Per wound care. Wash sacral ulcer with soap and water, rinse and pat dry. Santyl to central slough followed by single layer vashe moist gauze. Cover with dry secondary dressing . R3's Skin Observation tool dated 5/20/25, documents, in part: Sacrum. 7.3 cm in length, 5 cm in width, and 1 cm in depth . R3's Readmissions Data Collection Tool dated 5/20/25 documents in part: Skin Condition: Coccyx. R3's progress note dated 5/20/25 documents, in part: . [R3] is returning from the hospital after being admitted for ventilator-associated pneumonia. [R3's] skin is clear and moist, and [R3] has normal skin turgor, and mucus membranes are moist and pink . [R3] has a wound on [R3's] buttocks that is 7.3cm in length, 5cm in width, and 1 cm in depth. [R3] has an order to wash the sacral ulcer with soap and water, rinse and pat dry, apply Santyl to the central slough, followed by a single layer of vasche moist gauze. Surveyor reviewed R3's MD orders and noted the recommended wound treatment documented on the hospital discharge summary and in the facility progress note was not entered as an MD order for facility staff to follow. Surveyor noted the admission skin assessment documentation completed by facility staff did not document wound descriptors, such as granulation, necrotic, or slough or the current stage of the pressure injury. Surveyor reviewed R3's Electronic Medical Record (EMR) and progress notes. Surveyor noted facility staff did not document why the hospital discharge wound treatment recommendations were not followed upon R3's return to the facility. On 2/4/26 at 11:47 AM, Surveyor interviewed Registered Nurse (RN)-S. RN-S stated with new admissions, staff should verify orders with the MD right away and review hospital paperwork. Within the first hour of admission, facility staff complete a full skin assessment with descriptors, but staff do not stage wounds, the wound care nurse will stage but we do measurements and describe wound. On 2/9/26 at 9:41 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked what the process is for admission skin assessments. ADON-C stated the admitting nurse should contact the doctor and make sure orders are placed. The nurse should assess the skin. The assessment should include measurements of any area of concern. Surveyor asked if staging should be included in the admission assessment. ADON-C stated if a Licensed Practical Nurse (LPN) is completing the admission, then they just do measurements and do not stage. A Registered Nurse (RN) can then complete the skin assessment. The facility wound nurse is able to do a complete admission assessment with staging as well. Surveyor asked if wound descriptors like granulation, necrotic, or slough should be used. ADON-C stated yes and no. ADON-C stated that one person may think it's one thing and another may think it's another. The process should be that if an area is found, the nurse should call MD and the facility wound nurse right away and the wound nurse can do the full assessment. Surveyor reviewed R3's EMR and did not locate documentation of a different/additional admission wound assessment completed by the wound care nurse that documented the stage of R3's pressure injury on readmission back to the facility. Surveyor reviewed R3's TAR and noted facility staff treated R3's sacrum pressure injury with the previously entered treatment order of Calcium Alginate instead of the new treatment recommendations of Santyl documented on the Hospital Discharge Summary and the facility admission progress note. R3's MD order with a start date of 5/23/25 documents, in part: Sacrum [Pressure Injury (PI)]: Cleanse with wound cleanser f/b pat dry f/b skin prep to surrounding peri-tissue f/b calcium alginate to wound bed f/b bordered foam dressing every day shift for wound protection/healing. Surveyor noted the change to R3's sacrum treatment order included a change to the dressing. The previous dressing order included bordered gauze, the new treatment order included bordered foam dressing. Surveyor reviewed R3's EMR and did not locate another sacral skin assessment between 5/20/25 through 5/25/25. R3's Wound MD-R wound evaluation note dated 5/26/25, documents, in part: Stage 4 pressure wound sacrum full thickness. 5.86 x 4.58 x 0.1. 80% slough. 20% granulation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Additional wound detail: improved at readmission assessment but worsen [sic] from last visit before hospitalization. Treatment plan: Alginate calcium apply once daily. Surveyor noted this is the first documentation of the wound declining to a Stage 4 pressure injury. Surveyor reviewed R3's skin care plan and noted facility staff did not enter a new intervention after R3's wound was staged as a Stage 4 pressure injury, the care plan did not include person-centered interventions for turning or repositioning R3 and did not include an intervention regarding off-loading of R3's sacrum. On 5/31/25, R3 experienced a change in condition and was admitted to the hospital.R3 was readmitted back to the facility on 6/10/25. R3's 6/10/25 hospital discharge summary documents, in part: Diagnoses: Septic shock secondary to UTI (Urinary Tract Infection). R3's admission skin assessment dated [DATE] documents, in part: Sacrum. 8.5 x 6.5 x 1.5. Tunneling 12 o'clock-5 o'clock. Thick adherent slough covering 100% of wound bed. Surveyor reviewed R3's TAR and noted facility staff treated R3's Sacrum with the treatment order that was in place prior to this hospitalization. R3's Wound MD-R evaluation note dated 6/16/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 7.36 x 8.65 x 3.5. 5cm, undermining at 9 o'clock. 80% slough. 20% granulation . Treatment plan: Alginate calcium with silver apply once daily. Surveyor reviewed R3's MD orders and noted facility staff updated R3's MD order to reflect the new treatment plan of Calcium alginate with silver. R3's Wound MD-R evaluation note dated 6/23/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 6.72 x 7.26 x 3. 3cm undermining at 10 o'clock. 70% slough. 20% granulation. 10% bone. Treatment plan remained the same. Surveyor noted that MD-R documented 10% bone visualization within R3's sacrum wound. R3's skin care plan documented 2 new interventions initiated on 6/23/25 which included: X-ray [related to] 10% bone exposure. CT scan ordered to [rule out] osteomyelitis. R3's MD order with a start date of 6/23/25 documents: 2-view X-ray to sacrum. 10% bone exposure [rule out] osteomyelitis. R3's X-ray results of sacrum and coccyx dated 6/23/25 document, in part: No bony injury. Suboptimal evaluation due to excessive bowel gas and poor-quality images; lower sacral and coccygeal vertebrae not well visualized- repeat examination or CT scan of sacrum with coccyx is recommended. The x-ray results were entered into R3's medical record with a note dated 06/23/25 that states, Reviewed with [Wound MD-R] New order - CT scan. R3's progress note dated 6/23/25 at 4:30 PM documents, in part: X-ray results received. Impression reviewed with [Wound MD-R]. CT scan of sacrum with coccyx is recommended. [Wound MD-R] ordered CT scan. Order sent to [Wound MD-R], awaiting on signature of order to proceed with scheduling. Guardian . aware and agreeable, will be updated on date/time of scheduled CT scan. R3's MD order with a start date of 6/23/25 documents: CT scan of sacrum with coccyx [related to] Stage 4 pressure injury with 10% bone exposure. Surveyor reviewed R3's Medication Administration Record (MAR) and TAR and noted R3's CT scan order was checked off as completed on 6/23/25 at 5:43 PM. Surveyor reviewed R3's EMR for evidence that a CT scan was scheduled and did not locate a scheduled appointment or results of a CT scan. On 2/3/26 at 3:02 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated that DON-B was checking with Wound MD-R and the previous wound nurse who no longer works at the facility, Registered Nurse (RN)-O, to get more information about the CT scan. DON-B indicated it is unusual that it would not be scanned into the EMR but stated that DON-B would get back with Surveyor. On 2/4/26 at 12:51 PM, DON-B informed Surveyor DON-B spoke to Wound MD-R and RN-O about the ordered CT scan for R3. DON-B stated DON-B was told R3 ended up going to the hospital in July and the CT scan was completed then. DON-B stated DON-B also spoke with Receptionist-H, who oversees scheduling residents out of facility appointments. Receptionist-H did not have record that a CT scan needed to be scheduled for R3. On 2/4/26 at 12:58 PM, Surveyor interviewed Receptionist-H. Receptionist-H stated Receptionist-H reviewed the appointment calendar. From the start of R3's stay at the facility, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the only time R3 needed an outside appointment scheduled was a GI procedure that occurred on 2/3/25. Receptionist-H stated Receptionist-H was not given an order to try to schedule a CT scan for R3. Receptionist-H stated the typical process is for the nurse to get the order and have it signed off by the doctor. From there, the order is given to Receptionist-H. Receptionist-H will then fax the order to the MD office or hospital. It takes 2 to 3 days to get a date for the appointment or test on the calendar. On 2/4/26 at 1:57 PM, Surveyor interviewed Wound MD-R. Wound MD-R stated the sacrum x-ray was negative. The CT was ordered but the resident ended up going to the hospital before the CT scan was completed. Wound MD-R stated it was not emergent to get the CT and stated R3 was not septic when the CT was ordered. Wound MD-R indicated if Wound MD-R was concerned about infection in R3's wound, Wound MD-R would have sent R3 to the emergency room for a CT scan. Surveyor noted despite the MD order for a CT scan, there is no evidence an appointment was scheduled for R3 to get a CT scan completed. R3's progress note entered by DON-B on 6/28/25 documents, in part: Writer in to assess due to during dressing change, Resident noted to have labored Respirations, blank stare, ruddy color to cheeks, with increased foul drainage to wound. [Vital signs] show Hypotension at 117/53, [pulse] 90. [Respiratory rate] in to provide Respiratory care and suction, Oral care, Resident appears more alert. [Wound MD-R], Wound Nurse & On Call [Nurse Practitioner (NP)] updated, [New order] to obtain CBC, BMP STAT . Wound Nurse here and also assessed wound with Writer. Will continue to monitor for any further changes. Dressing treatment order changed via Wound Team . Surveyor noted DON-B and previous wound nurse, RN-O, assessed R3's wound on 6/28/25 and noted an increased foul drainage to wound, which can be an indication of infection to the wound. R3's MD order with a start date of 6/28/25 documents: Sacrum PI: Cleanse with Dakin's 1/2 strength solution f/b pat dry f/b skin prep to surrounding peri-tissue f/b wet to moist gauze (soaked with Dakin's 1/2 strength solution) f/b bordered gauze dressing two times a day for wound protection/healing. Surveyor noted R3's wound treatments changed from daily to two times a day. R3's lab results dated 6/28/25 document R3's [NAME] Blood Cell (WBC) results as high at 14.1. The reference interval range for WBCs is from 4 to 10. In comparison, R3's previous WBC results completed on 6/25/25 were 7.6. Surveyor noted R3's WBC almost doubled in 3 days which can be an indication of infection. R3's progress note dated 6/28/25 at 4:20 PM, documents, in part: Lab results communicated . to on call NP. Elevated WBC 14.0. [New order] to obtain [urinalysis (UA), culture and sensitivity (C&S) and STAT chest x-ray] . Surveyor reviewed R3's EMR and noted the UA, C&S and STAT chest x-ray were completed. R3's chest x-ray results dated 6/29/25 document, in part: No significant interval changes as compared to the previous study, 5/23/25. Surveyor reviewed R3's lab results and noted the UA and C&S had resulted in a diagnosis of Urinary Tract Infection (UTI). A one-time dose of Fosfomycin Tromethamine was ordered and given by facility staff on 7/2/25. R3's Wound MD-R evaluation note dated 6/30/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 6.72 x 7.26 x 3. 3cm undermining at 10 o'clock. 70% slough. 20% granulation. 10% bone. Treatment plan: Sodium hypochlorite solution (Dakins) apply twice daily . 1/2 strength cleanse and wet to moist to prevent odor and infection . Gauze Island with border . R3's WBC results dated 7/2/25 document a result of 12.8 (still elevated.) R3's Wound MD-R evaluation note dated 7/7/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 4.4 x 4.8 x 2.5. 2.5cm undermining at 10 o'clock. Heavy Serous exudate (large volume of thin, watery, and clear or pale-yellow fluid draining from a wound). 70% slough. 20% granulation. 10% bone. Secondary dressing plan: foam with border. Surveyor noted R3's treatment remained the same but Wound MD-R recommended a change in the secondary dressing. Surveyor reviewed R3's MD sacrum PI treatment order with a start date of 7/7/25 and noted facility staff changed the MD order to reflect Wound MD-R's recommended secondary dressing. R3's Wound MD-R (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evaluation note dated 7/14/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 5.9 x 6.2 x 2.5. 2.5cm, undermining at 10 o'clock. 50% slough. 40% granulation. 10% bone. Treatment plan remains the same. R3's Medical Doctor (MD)-Q note dated 7/14/25 at 10:15 AM, documents, in part: . Wound care just visited with [R3]. Wounds are stable. R3's WBC results dated 7/16/25 documents a high result of 12.8. Surveyor noted R3's WBC remained elevated. R3's progress note dated 7/19/25 at 2:26 PM, documents, in part: . [Certified Nursing Assistant] staff had emptied residents foley and noted a moderate amount of blood. Writer irrigated foley and changed tubing of resident's catheter to monitor for new blood . Writer updated care team. Writer returned to bedside where there continued to be blood in the catheter and urine bag. It had been approximately 15 minutes since previous vitals were taken, and writer ran another set. Blood pressure was now 100/62, . 101.9 temp. Writer updated care team of new vitals and that resident was being sent [to hospital] . R3 was sent to the hospital on 7/19/25. R3's hospital Discharge summary dated [DATE] documents, in part: Discharge Diagnoses: Shock, likely septic and hypovolemic (resolved), Sepsis [secondary to] sacral osteomyelitis +/- UTI +/- [pneumonia]. [R3 presented] from facility for hematuria, found to be hypotensive/febrile with imaging [concerning for] sacral osteomyelitis, [left lower lobe] pneumonia, and UTI all pointing towards septic shock. [Status post] [Operating Room] debridement 7/21/25. R3's Hospital certified wound nurse consult note dated 7/22/25 documents, in part: . [R3] hospitalized [due to] being febrile and hypotensive. CT done on 7/19 which resulted as Large sacral decubitus ulcer with lower sacral/coccygeal osteomyelitis and presacral abscess. [Acute Care Surgery] consulted and debrided coccyx with partial coccygectomy yesterday, 7/21. R3's Hospital Infectious Diseases consult note dated 7/22/25 documents, in part: . [R3]. admitted with septic shock. CT notable for sacral/coccygeal osteomyelitis with presacral abscess. Underwent debridement with [acute care surgery] on 7/21. Most likely source of [R3's] sepsis seems to be [R3's] sacral wound with associated abscess. Based on notes from [R3's] most recent outside hospitalization, [R3] appears to be close to [R3's] baseline ventilator requirement and is clear lungs on exam, so we have lower suspicion for pneumonia as a driving process. [Urine culture] not [consistent with] infection. R3's hospital after visit summary dated 8/15/25 documents the following instructions for wound care: Sodium hypochlorite 0.5% solution. Commonly known as Dakins (full strength) apply externally as needed for wound care. R3 was readmitted back to the facility on 8/15/25. R3's admission skin assessment dated [DATE] documents, in part: Sacrum - Unstageable. 8 x 11.5 x 4. Undermining 9 to 3 [with] deepest at 1 of 3cm. R3's admission summary progress note entered by DON-B, dated 8/15/25 at 4:26 PM, documents, in part: Wound Sacrum Unstageable. measures 8.0 cm x 11.5 cm x 4.0 cm with undermining from 9 o'clock to 3 o'clock deepest at 1 o'clock 3cm, moderate serosanguinous drainage, no odor, bone exposed, wound bed clean . NP updated . orders confirmed. Surveyor noted facility staff documented an admission wound assessment but staged the wound incorrectly as an Unstageable instead of a Stage 4 pressure injury. R3's MD order with a start date of 8/16/25 documents, Treatment to sacral wound: Cleanse with Dakins, loosely pack with Dakins soaked gauze and cover with ABD, change [two times a day] and [as needed]. R3's Wound MD-R evaluation note dated 8/18/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 10.5 x 10 x 4. 5cm at 1 o'clock. 30% necrotic. 60% granulation. 10% bone. Treatment plan: Sodium hypochlorite solution (Dakins) apply twice daily . 1/2 strength cleanse and wet to moist to prevent odor and infection. Foam with border apply twice daily.Wound MD-R's recommendation for half strength Dakins and a foam with border dressing was not updated on R3's TAR; staff continued to treat the sacral pressure injury with full strength Dakins and covered the wound with an ABD pad. R3's Wound MD-R evaluation note dated 8/25/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 13 x 7 x 4. 7cm undermining (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 2 o'clock. 30 % necrotic. 60% granulation. 10% bone. Treatment plan: Sodium hypochlorite solution (Dakins) apply twice daily . 1/2 strength cleanse and wet to moist to prevent odor and infection. Foam with border apply twice daily. Surveyor noted R3's wound had grown. The facility did not update R3's skin care plan with any new interventions and there is still no intervention for turning and repositioning R3 or offloading the sacrum. Staff continue to treat R3's sacral pressure injury with full strength Dakins and cover the wound with an ABD pad instead of a foam with border dressing as ordered.MD-R continued to see R3 weekly for wound evaluation. MD-R recommended on 9/1, 9/8, 9/15, and 9/22 the treatment to R3's sacrum wound be Sodium hypochlorite solution (Dakins) apply twice daily . 1/2 strength cleanse and wet to moist to prevent odor and infection. Foam with border apply twice daily. R3's TAR indicated during the month of September, facility staff continued to treat R3's sacral pressure injury with full strength Dakins and cover the wound with an ABD pad instead of a foam-with-border dressing as ordered. R3's Wound MD-R evaluation note dated 9/29/25 documents, in part: Stage 4 pressure wound sacrum full thickness. 7 x 8 x 5. 6cm at 3 o'clock. 30% slough. 40% granulation. 30% bone. Treatment plan: Sodium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 of 1 resident (R3) received the necessary comprehensive assessment or care and treatment for indwelling catheter use. R3 was admitted to the facility on [DATE] with urinary incontinence and at some point, after the admission, the facility was unable to determine when, R3 received an indwelling catheter. There was no physician order for the indwelling catheter, no comprehensive assessment of the catheter and no comprehensive care plan directing the care and treatment of the catheter. On 5/31/25, R3 was discharged to the hospital for a change in condition and was diagnosed with septic shock secondary to UTI (urinary tract infection). The facility's failures contributed to R3 developing septic shock secondary to UTI due to an indwelling catheter. This created a finding of immediate jeopardy that began on 5/31/25. Surveyor notified Nursing Home Administrator (NHA) of the immediate jeopardy on 2/10/26 at 12:46 pm. The immediate jeopardy was removed on 2/13/26. However, the deficient practice continues at a scope/severity of D as the facility continues to implement its action plan.Findings include:The facility's catheter care, urinary policy and procedure with a review date of 11/2025 documents:Catheter Evaluation1. Review and document the clinical indications for catheter use prior to inserting. 2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Use a standardized tool for documenting clinical indications for catheter use.3. Remove the catheter as soon as it is no longer needed.ComplicationsObserve the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately:If the resident indicates that his or her bladder is full or that he or she needs to void;If urine has an unusual appearance (i.e. color, blood, etc);In the event of bleeding, or if the catheter is accidently removed;If the resident complains of burning, tenderness, or pain in the urethral area; orIf signs and symptoms of urinary tract infection or urinary retention occur.R3 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), anoxic brain damage, and heart failure. R3's admission Minimum Data Set (MDS) dated [DATE] documents R3 is severely cognitively impaired and is dependent on staff for all activities of daily living (ADLs). It also documents R3 is always incontinent of bladder. R3's admission Care Area Assessment (CAA) dated 1/27/25 documents R3 is incontinent of bladder and is dependent upon staff for incontinence care.The care plan for bladder incontinence related to anoxic brain damage was initiated on 4/7/25. The discharge-return anticipated MDS dated [DATE] documents R3 as having an indwelling catheter.The quarterly MDS dated [DATE] documents R3 has an indwelling catheter. R3's medical record does not include physician orders for an indwelling catheter, and the care plan does not address indications for the use of an indwelling catheter or the care and treatment required. There is also no evidence to show when the catheter started.R3's Medication Administration Record (MAR) dated 5/22/25 documents: Record foley output every shift. The nurses note dated 5/28/25 documents: lab work obtained to monitor R3's anemia and elevated white blood cell (WBC) count due to R3's recent prednisone use. The blood work was abnormal and an order to repeat the lab work on 5/30/25 was obtained. The lab work identified a Hemoglobin of 7.3 and Hematocrit of 24. Surveyor notes R3's Hemoglobin and Hematocrit are low.The nurses note dated 5/31/25 at 2:44 a.m., documents: the lab results were communicated with the on-call provider, and an order was received to repeat the lab work on 6/2/25.The nurses note dated 5/31/25 at 9:29 a.m., documents: R3's assessment revealed R3 was hypotensive, experiencing increased oxygen needs and increased secretions so an order was obtained to send R3 to the hospital.The hospital discharge summary for the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospitalization on 5/31/25 through 6/10/25 documents R3 was treated for septic shock secondary to urinary tract infection (UTI). Upon return from the hospital, there was no order for the catheter, and no care plan to direct the care and treatment staff should be completing related to the catheter. On 9/11/25, nearly 5 months after the placement of the catheter, R3's physician ordered a 16 French indwelling catheter to promote wound healing and change foley catheter as needed if blockage or obstruction. On 9/12/25, physician order documents to irrigate foley catheter with 30 milliliters (ml) of normal saline twice a day (BID)On 10/28/25, nearly 6 months after the placement of the catheter, a care plan for urinary catheter to promote wound healing was developed. On 2/5/26 at 11:30 a.m., Surveyor interviewed Director of Nursing (DON)-B about R3's catheter. DON-B stated she thinks when R3 came back from one of her earlier hospitalizations, she returned to the facility with a catheter, and the nurses didn't get an order or assess for use of the catheter. DON-B stated maybe at some point, one of the nurses consulted with Wound MD-R and it was agreed that the indwelling catheter was needed for wound healing. DON-B stated she didn't have an explanation for it. The facility's failure to comprehensively assess the need for the catheter, obtain a physician's order for its use, and develop a care plan for the care and treatment of the catheter created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed on 2/13/26, however, continues at a scope/severity of D as the facility continues to implement the following action plan: *All facility nurses re-educated on ensuring that all residents with a foley catheter have an order for the foley catheter along with standard foley catheter orders such as catheter changes, catheter flushing, changing graduate, having a barrier under graduate when draining bag, changing catheter drainage bag, etc.*Director of Clinical Services (DCS) to assist with providing and explaining re-education to facility nurses.*DCS assisted with providing 1:1 education with Interdisciplinary team nurses on 2/10/26 to facilitate and ensure understanding and expectation(s) of processes and policy related to catheter care/orders and to include updating care plans.*DCS(s) will assist with updating/creating individualized care plans. Nursing staff re-educated to complete foley catheter care q shift and prn.* Nursing staff re-educated about changing out catheter materials biweekly and prn. Policy used as reference and guide during training. All training to floor staff to be completed by their next working shift.*All facility nurses re-educated on ensuring that all residents with a foley catheter have an order for the foley catheter along with standard foley catheter orders such as catheter changes, catheter flushing, changing graduate, having a barrier under graduate when draining bag, changing catheter drainage bag, et.* Director of Clinical Services (DCS) to assist with providing and explaining re-education to facility nurses.*DCS assisted with providing 1:1 education with Interdisciplinary team nurses on 2/10/26 to facilitate and ensure understanding and expectation(s) of processes and policy related to catheter care/orders and to include updating care plans.*DCS(s) will assist with updating/creating individualized care plans.*Nursing staff re-educated to complete foley catheter care q shift and prn. Nursing staff also re-educated about changing out catheter materials biweekly and prn. Policy used as reference and guide during training. All training to floor staff to be completed by their next working shift.*Audits will be conducted by DCS or designee on admissions and re-admissions with foley catheters to ensure foley catheter diagnosis and care orders are in place and that foley catheters are care planned appropriately per policy.*Audits will be conducted 2X a week for six weeks by DCS or designee to ensure competency and compliance with catheter care. Audits will be conducted 2x/week x six weeks to ensure compliance with changing out catheter care materials biweekly.*DCS or designee will review/audit POC charting Monday through Friday (Monday will include 72 hr review) to review catheter care tasks not completed - ad hoc education will be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided as indicated by DCS or designee for catheter care tasks not completed.*Audits will be reviewed at the monthly QAPI meeting to determine trends or patterns of concern and/or if further education is needed until substantial compliance has been achieved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility did not ensure 1 (R5) of 3 residents who are fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding.During personal care observations on 2/5/25 R5's head of the bed was lowered flat while the tube feeding continued to be running.Findings include:On 2/9/26 Surveyor requested the facility's Tube Feeding policy. On 2/10/26 Regional Nurse-D informed Surveyor she can't locate a Tube Feeding policy and provided an audit form. The facility's Tube Feeding Audit Form not dated under Criteria documents, Head of bed elevated to 30-45 degrees during feedin [sic] (feeding).R5's diagnoses includes anoxic brain damage (brain is deprived of oxygen leading to cell death), dysphagia (difficulty swallowing), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), quadriplegia (paralysis of all four limbs), and pneumonitis (inflammation of the alveoli or air sacs in the lungs) due to inhalation of food and vomit.R5's alteration in ability to consume food and/or fluids and requires enteral feeding via G (gastrostomy) tube to maintain adequate caloric and nutritional status care plan initiated 4/19/25 & revised 5/19/25 includes an intervention of Hold feeding when giving care, turning and repositioning. Resume when complete and HOB (head of bed) up. Initiated & revised 4/19/25.On 2/5/26, at 12:30 p.m., Surveyor observed Certified Nursing Assistant (CNA)-J place gloves on and entered R5's room. CNA-J stated to R5's boyfriend look at this face here. CNA-J lowered R5's head of the bed flat and removed R5's gown. Surveyor observed R5's Nepro 1.8 tube feeding is running at 45 ml (milliliters). CNA-J did not turn off R5's tube feeding prior to lowering the head of the bed flat. At 12:33 p.m. Respiratory Therapist (RT)-DD entered R5's room. CNA-J asked RT-DD to check R5's trach collar as she thought it was too loose. RT-DD tightened R5's trach collar and then left R5's room. CNA-J gathered her supplies. At 12:36 p.m. Surveyor asked CNA-J about R5's tube feeding being on while R5 was laying flat. CNA-J informed Surveyor that she usually turns it off and placed R5's tube feeding on hold.On 2/9/26, at 2:20 p.m., Surveyor asked Assistant Director of Nursing (ADON)-C if a resident's tube feeding is running and a CNA is going to do cares for this resident what is the expectation. ADON-C replied stop the tube feeding. Surveyor informed ADON-C of the observation of R5's tube feeding not being stopped during cares until Surveyor spoke with CNA-J.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation and interview, the facility did not ensure sufficient nursing staff to meet resident care needs for residents residing in the ventilator unit. This has the potential to affect 11 ventilator residents and 2 residents with tracheostomies.On 2/5/26 the facility's ventilator unit was staffed with Respiratory therapist (RT)-DD, Licensed Practical Nurse (LPN)-BB and Certified Nursing Assistant (CNA)-J. Facility staff assigned to the vent unit work 12-hour shifts. Times of the shifts are 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. On 2/5/26 Surveyor conducted continuous observations on the ventilator unit starting at 8:36 a.m. and until 1:40 p.m. During this observation Surveyor did not observe R5 being provided with incontinence cares & repositioning until 12:31 p.m. at which time R5 incontinence product was saturated with urine and R5 had a bowel movement. R12 was not provided with incontinence cares & repositioning until 12:57 p.m. R7 was not provided with incontinence care & repositioning until 1:18 p.m. R7's incontinence product was saturated with urine and the sheet under R7 was wet with urine. R7 also had a bowel movement. R8, R9, & R11 have indwelling urinary catheters. Surveyor did not observe CNA-J enter R8, R9, or R11's room to check for bowel incontinence or reposition these residents while Surveyor was on the unit for five hours.Findings include:The facility assessment reviewed February 2026 documents [Facility's initials] is licensed skilled nursing facility with a specialized ventilator unit. Further documentation includes This document is used to inform staffing decisions to ensure there are significant number of staff with the appropriate competencies and skill sets necessary to care for its member needs as identified through resident assessments and plans of care. For instance, the Ventilator Unit, staffs with a higher staff to member ration due to increased needs. Under Part 1: Member Profile for Bed capacity documents 87. Under Number of Member Care Floors and Bed Capacity per Floor documents 4 Member Care Units. Vent=13 beds, Rehab=16 beds, West=20 beds, and East=17 beds. Under Part 3: Facility Resources Needed to Provide Competent Support and Care for our Member Population Every Day and During Emergencies for Staffing plan documents Based on the member population and their needs for care and support, [facility's initials] shall use the following general staffing plan on a day-to-day basis. In emergency situations including nights and weekends, the staffing plan shall include the use of all available resources to carry out care needs and support. This may include the use of certified nursing assistants working in other than nursing assistant positions such as nurse schedulers, restorative aides (RA), activities, etc. Other resources which would be called upon to ensure care needs and support continue include the use of member families/loved ones, volunteers, and any available community resources (collaboration with other nursing facilities), emergency government, local officials, etc. Under Facility Wide totals documents DON (Director of Nursing): 1 FT (full time), UM (Unit Manger) 1 FT, Lead Nurse RN (Registered Nurse) Vent: 1 FT, MDS (minimum data set) RNs: 1 PT (part time), RNs: 2 FT, 3 PT, LPNs (Licensed Practical Nurse): 6 FT, 5 PT, Respiratory Therapist: 1 FT. CNA (Certified Nursing Assistants) FT 10, PT 27, Agency use as indicated. Under the section floor documents Nurse Charge: AM (day): 1, PM (evening): 1, NOC (night):1 Direct Care RN AM:1, PM: 1, NOC: 1. Direct Care LPN: AM: 3, PM:3, NOC 1. Medication Technician: 1 with indicated adjustments above. CNA: 8AM; 8 PM; 5 NOC. Emergency need=depends on emergency. Would allocate all resources needed and flex schedules to ensure adequate 24/7 coverage.On 2/4/26, at 3:27 PM, a Surveyor interviewed CNA-K. CNA-K indicated staffing on the vent unit is challenging. CNA-K states there is only one scheduled CNA on the vent unit at all times. CNA-K stated there is about 12 to 13 residents that CNA-K has to care for during the day. Most of the residents are dependent for all of their care and it is hard to get everything done. CNA-K stated they need 2 CNA's on the vent unit.On 2/5/26, at 7:40 AM, a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor interviewed CNA-J. CNA-J stated CNA-J has worked at the facility since November of last year. CNA-J was hired to work on the vent unit. CNA-J stated there is only one CNA scheduled to work on the vent unit. CNA-J indicated the facility needs to schedule 2 CNAs on the vent unit because most of the residents are dependent on staff for everything and you need 2 people to help with cares and mobility.On 2/5/26 the facility's ventilator unit was staffed with Respiratory Therapist (RT)-DD, Licensed Practical Nurse (LPN)-BB and Certified Nursing Assistant (CNA)-J. Facility staff assigned to the vent unit work 12-hour shifts. Times of the shifts are 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. On 2/5/26 Surveyor conducted continuous observations on the ventilator unit starting at 8:36 a.m. and until 1:40 p.m. During this observation Surveyor did not observe R5 being provided with incontinence cares & repositioning until 12:31 p.m. at which time R5 incontinence product was saturated with urine and R5 had a bowel movement. R12 was not provided with incontinence cares & repositioning until 12:57 p.m. R7 was not provided with incontinence care & repositioning until 1:18 p.m. R7's incontinence product was saturated with urine and the sheet under R7 was wet with urine. R7 also had a bowel movement. R8, R9, & R11 have indwelling urinary catheters. Surveyor did not observe CNA-J enter R8, R9, or R11's room to check for bowel incontinence or reposition these residents while Surveyor was on the unit for five hours.On 2/5/26, at 8:38 a.m., Surveyor interviewed Respiratory Therapist (RT)-DD, who is also the Respiratory Director for the ventilator unit and working the floor today. RT-DD informed Surveyor there are 13 residents today, 11 ventilator residents and 2 residents with trachs. RT-DD explained they are responsible for maintaining airway for residents with ventilators and trachs. Respiratory and nursing share suctioning. Surveyor asked RT-DD if they are responsible for repositioning residents. RT-DD explained they don't but if they are asked for help, they can help nursing with this. RT-DD informed Surveyor they make sure resident's head of bed are elevated for tube feeding and airway. RT-DD informed Surveyor they don't move residents around; they may move their neck and head other than that it's out of their scope of practice.On 2/5/26, at 8:51 a.m., Surveyor asked Certified Nursing Assistant (CNA)-J if there are any residents that require to be fed. CNA-J replied to no. CNA-J explained there are three residents who eat and just need set up. The remaining residents are tube fed, nothing by mouth.On 2/5/26, at 11:07 a.m., CNA-J informed Surveyor she did rounds before. CNA-J informed Surveyor she knows rounds are every two hours but it's just her with 13 residents and she's going to do the best she can.On 2/5/26, at 11:28 a.m., Surveyor asked Licensed Practical Nurse (LPN)-BB if she is responsible for doing resident's treatments. LPN-BB informed Surveyor the treatments were done at night because they take so long. LPN-BB informed Surveyor she's responsible for medications and tube feeding. Surveyor asked LPN-BB if she repositions or provides continence cares to residents. LPN-BB replied if they need help. Surveyor asked LPN-BB if she would reposition or provide continent cares on her own. LPN-BB replied no that's what she's here for, referring to CNA-J.On 2/5/26, at 12:14 p.m., Surveyor asked CNA-J which residents get out of bed. CNA-J informed Surveyor R6 & R10 are up due to therapy and R5 is gotten up on Monday, Wednesday, & Friday per family request. Surveyor inquired if there are any residents on the vent unit who are not dependent on staff. CNA-J informed R14 & R15 are the only ones that are self-care. CNA-J explained they just go behind to see if there is something they can't do. Surveyor asked if the rest of the residents on the vent unit are dependent upon staff. CNA-J replied yes, fully dependent.On 2/5/26, at 12:39 p.m., Surveyor asked CNA-J what time she did her first rounds this morning. CNA-J informed Surveyor 6:00, 6:15 a.m. after report. CNA-J informed Surveyor she checked on people to make sure they were living and breathing, emptied foleys, if they had a BM (bowel movement). CNA-J informed Surveyor after breakfast she does her check and change and stated this is considered my 2nd round of the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/26, at 12:55 p.m., Surveyor verified with CNA-J she just started her second rounds for residents. CNA-J stated to Surveyor you see how busy I was, couldn't get to it. CNA-J informed Surveyor when she was hired, they said there is two CNAs on each shift, I don't know what's going on the last few weeks.On 2/5/26, at 1:16 p.m. Surveyor asked CNA-J about the residents who reside in the short hall, R8, R9, and R11. CNA-J informed Surveyor they have catheters. Surveyor asked if she has checked R8, R9, or R11 for bowel incontinence or has she repositioned any of these residents. CNA-J informed Surveyor she's been a CNA for 25 years and there are no two-hour check and change. CNA-J informed Surveyor these residents are not on a schedule.*R5's diagnoses include anoxic brain damage (brain is deprived of oxygen leading to cell death), dysphagia (difficulty swallowing), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), and quadriplegia (paralysis of all four limbs). R5 has a feeding tube and tracheostomy.R5's quarterly MDS (minimum data set) with an assessment reference date of 11/21/25 assesses R5 as having short term & long-term memory problems and is severely impaired for cognitive skills for daily decision making. R5 is dependent on staff for eating, toilet hygiene, roll left and right, and chair/bed to chair transfers. Indwelling catheter is yes and R5 is always incontinent of bowel. R5's foley catheter was discontinued on 10/25/25.On 2/5/26, at 12:27 p.m., Surveyor observed Certified Nursing Assistant (CNA)-J rolled a linen cart outside R5's room. Surveyor observed there is an enhanced barrier precautions sign outside R5's room and a PPE (Personal Protective Equipment) cart.On 2/5/26, at 12:30 p.m., Surveyor observed CNA-J place gloves on and entered R5's room. CNA-J did not place a gown on. CNA-J stated to R5 boyfriend look at this face here. CNA-J lowered R5's head of the bed flat and removed R5's gown. At 12:33 p.m. Respiratory Therapist (RT)-DD entered R5's room. CNA-J asked RT-DD to check R5's trach collar as she thought it was too loose. RT-DD tightened R5's trach collar and then left R5's room. CNA-J gathered her supplies. CNA-J washed R5's face, upper body, shut R5's room door, removed her gloves and washed her hands. CNA-J placed gloves on, unfastened R5's saturated product, and washed R5's frontal area removing bowel movement. CNA-J positioned R5 on the right side and washed R5's buttocks to remove bowel movement. CNA-J folded the draw sheet as the sheet became soiled with stool. At 12:43 p.m. CNA-EE entered R5's room, CNA-J asked CNA-EE if she could get her a draw sheet which CNA-EE did. Surveyor observed that CNA-EE has only gloves on and is not wearing a gown. CNA-EE positioned R5 from side to side while CNA-J removed soiled items, placed a new draw sheet on R5's bed and incontinent product on. CNA-EE placed soiled items in bag, removed gloves, and washed her hands. CNA-EE place gloves on and a gown was placed on R5. CNA-J raised the foot portion & head of the bed up and lowered the bed down. CNA-J placed pillows under R5's arms, restarted R5's tube feeding and stated she was going to wash her hands. Surveyor noted this is the first observation of cares being provided to R5 since Surveyor was on the vent unit starting at 8:36 a.m. and according to CNA-J her first rounds were after report starting at 6:00-6:15 a.m.*R12's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), and dysphagia (difficulty swallowing). R12 has a feeding tube and tracheostomy.R12's quarterly MDS (minimum data set) with an assessment reference date of 12/24/25 is marked yes for comatose. R12 is assessed as being dependent upon staff for eating, toileting hygiene, roll left and right, and chair/bed to chair transfer. R12 is always incontinent of bowel and bladder.On 2/5/26, at 12:57 p.m., Certified Nursing Assistant (CNA)-J informed Surveyor she was going to do, referring to incontinent cares, for R12. CNA-J wheeled the linen cart over to R12's room, placed gloves on, and entered R12's room. At 1:01 p.m., Surveyor observed CNA-J open R12's door and remove linen from the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cart.Surveyor noted this is the first observation of cares being provided to R12 since Surveyor was on the vent unit starting at 8:36 a.m. and according to CNA-J her first rounds were after report starting at 6:00-6:15 a.m.*R7's diagnoses includes myotonic muscular dystrophy (multisystem genetic disorder characterized by progressive muscle wasting, weakness, and delayed relaxation), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide) with hypoxia (low levels of oxygen), dysphagia (difficulty swallowing), and anxiety disorder (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating). R7 has a feeding tube, tracheostomy, and is on a ventilator.R7's quarterly MDS (minimum data set) with an assessment reference date of 1/21/26 assesses R7 as short term & long-term memory as ok and is modified independence for cognitive skills for daily decision making. R7 is assessed for eating as non-applicable. Toileting hygiene, roll left and right is dependent. Chair/bed to chair transfer is assessed as not applicable. Yes, is marked for an indwelling catheter and R7 is always incontinent of bowel.R7's bowel and bladder evaluation dated 1/21/26 for bowel continence always incontinence is checked and urinary continence always incontinence is checked.R7's foley catheter was discontinued on 1/26/26.On 2/5/26, at 1:18 p.m. Surveyor entered R7's room with Certified Nursing Assistant (CNA)-J who had placed gloves on. Surveyor introduced self and asked permission to observe cares. R7 shook her head yes. CNA-J placed R7's tube feeding on hold, lowered the head of the bed flat, and removed R7's bedding. CNA-J unfastened R7's incontinence product which was saturated with dark yellow urine. CNA-J moved the garbage can over to the side of the bed and using a disposable wipe, wiped R7's inner thighs and frontal perineal area from front to back. CNA-J pulled R7 to the left side of the bed and rolled R7 onto her right side. Surveyor observed a large amount of stool in R7's rectal area and on R7's buttocks. CNA-J wiped R7 with the incontinence product and removed the incontinence product. Surveyor observed the sheet under R7 is wet with urine. CNA-J indicated she is going to have to change the sheets. CNA-J wiped R7's rectal area and buttocks with a disposable wipe and R7 was positioned on her back. CNA-J removed her gloves, went to the linen cart for a sheet and placed gloves on. CNA-J removed the soiled fitted sheet on the right side and placed a clean fitted sheet on. R7 was positioned on the side, barrier cream was applied on R7's buttocks, and a product placed under R7. R7 was positioned on the left side, CNA-J removed the soiled sheet, placed the fitted sheet on the other side of the bed, applied barrier cream on R7's inner thighs, and fastened R7's incontinence product. R7 was covered with a sheet & blanket.Surveyor noted this is the first observation of cares being provided to R7 since Surveyor was on the vent unit starting at 8:36 a.m. and according to CNA-J her first rounds were after report starting at 6:00-6:15 a.m.R9's diagnoses includes hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting right dominate side, chronic respiratory failure (long term condition where the lungs cannot adequate exchange oxygen and carbon dioxide) with hypoxia (low levels of oxygen), hypertension (high blood pressure) and atrial fibrillation (irregular and rapid heartbeat). R7 has a feeding tube, tracheostomy, and is on a ventilator.R9's admission MDS (minimum data set) with an assessment reference date of 12/30/25 assesses R9 as being comatose. R9 is dependent on eating, toileting hygiene, roll left and right, and chair/bed to chair transfer. R9 has an indwelling urinary catheter and is always incontinent of bowel.On 2/5/26, at 10:53 a.m., Surveyor observed Director of Nursing (DON)-B and CNA-J walk down the hall and enter R9's room. At 10:55 a.m., DON-B and CNA-J left R9's room. At 11:04 a.m. DON-B left the vent unit. At 11:05 a.m. Surveyor asked CNA-J when she went in R9's room with DON-B did they do any cares. CNA-J informed Surveyor they didn't do any cares and they just talked.Surveyor did not observe CNA-J provide (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any bowel incontinence cares or reposition R9 while Surveyor was on the unit from 8:36 a.m. to 1:40 p.m.*R8's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), amyotrophic lateral sclerosis (progressive neurodegenerative disease that destroys motor neurons in the brain and spinal cord leading to severe muscle weakness, paralysis and eventually respiratory failure), dysphagia (difficulty swallowing), and anoxic brain damage (brain is deprived of oxygen leading to cell death). R8 has a feeding tube, tracheostomy, and is on a ventilator.R8's admission MDS (minimum data set) with an assessment reference date of 12/29/25 documents R8 has short- and long-term memory problems and is severely impaired for cognitive skills for daily decision making. R8 is assessed as being dependent for eating, toileting hygiene, roll left and right, and chair/bed to chair transfer. R8 has an indwelling urinary catheter and is always incontinent of bowel. R8's bowel incontinence care plan initiated & revised 10/17/25 includes an intervention of Check resident every two hours and assist with toileting as needed. Initiated 10/17/25.Surveyor did not observe CNA-J provide any bowel incontinence cares or reposition R8 while Surveyor was on the unit from 8:36 a.m. to 1:40 p.m.*R11's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), dysphagia (difficulty swallowing), quadriplegia (paralysis of all four limbs), and anoxic brain damage (brain is deprived of oxygen leading to cell death). R11 has a feeding tube, tracheostomy, and is on a ventilator.R11's quarterly MDS (minimum data set) with an assessment reference date of 1/23/26 assesses R11 as being comatose. R11 is dependent on toileting hygiene and roll left and right. Chair/bed to chair transfer is not attempted. R11 has an indwelling urinary catheter and is always incontinent of bowel.Surveyor did not observe CNA-J provide any bowel incontinence cares or reposition R11 while Surveyor was on the unit from 8:36 a.m. to 1:40 p.m.On 2/9/26, at 1:03 p.m. asked Nursing Home Administrator (NHA)-A about staffing on the ventilator unit. NHA-A informed Surveyor they have discussed safe staffing on the unit and staffing is based on acuity. Surveyor stated to NHA-A you staff the unit with one RT, one nurse, and one CNA, correct? NHA-A replied correct. Surveyor asked NHA-A how they can expect one CNA to provide care for eleven dependent residents. NHA-A informed Surveyor they don't expect just the CNA to provide all the cares, the nurses are willing to help, one person is one person. Surveyor informed NHA-A of the concerns of residents not being provided incontinent cares and repositioning for an extended period or not provided at all as Surveyor was on the ventilator unit on 2/5/26 for five hours continuously. NHA-A informed Surveyor what Surveyor witnessed was based on staff of one, one, & one referring to one RT, one nurse, and one CNA. NHA-A informed Surveyor they did add an additional CNA. Today they were supposed to have two CNAs but they had a call in. Surveyor asked NHA-A when the additional CNA was added. NHA-A informed Surveyor she won't give Surveyor a definitive date. Surveyor asked NHA-A when they have call ins what is done to replace staff. NHA-A replied we do everything possible in house and then there is [name of agency]. Surveyor asked what does we do everything possible mean. NHA-A informed Surveyor they offer bonuses, ask staff to come in, they will trade days.On 2/9/26, at 1:12 p.m., Surveyor met with Human Resource Assistant (HRA)-I, who is the scheduler, to discuss staffing on the vent unit. HRA-I informed Surveyor if there are 12 residents there is one CNA, one nurse, and one RT but she doesn't staff the RTs. Surveyor asked HRA-I if the staffing is based on census. HRA-I replied yes. Surveyor asked when she would staff two CNAs on the vent unit per shift. HRA-I informed Surveyor when they have 15 residents. HRA-I informed Surveyor today they have one CNA working and on the PM shift they will have 1.5. Surveyor asked HRA-I to explain this as the ventilator unit works two 12-hour shifts. HRA-I explained a CNA will work on the north or west unit until 10:00 p.m. and then they will float over to the vent unit and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	work there until 6:00 a.m. HRA-I informed Surveyor the CNA will get their 12 hours, they are just utilizing the CNA better. Surveyor asked HRA-I what she does when staff call in to replace the call in. HRA-I explained sometimes staff don't follow the rules as they call the facility and not her. The nurse who receives the call in will call her. HRA-I informed Surveyor staff are to call in one hour before their shift but most of the time they call after their shift starts so it's complicated to get someone. Surveyor asked HRA-I if she had two CNAs scheduled for the ventilator unit today. HRA-I replied only one. Surveyor asked if there were any call-ins today. HRA-I informed Surveyor they had 2 call offs. Surveyor asked where they were scheduled to work. HRA-I informed Surveyor one on rehab and the other on north. Surveyor asked when they call in what does she do. HRA-I informed Surveyor she will call staff, send out a mass text asking if anyone can come in and help. HRA-I informed Surveyor she'll wait 15 minutes and then goes into [name of agency] to put a shift in. Surveyor asked what happens if staff won't come in and they can't get anyone from the agency. HRA-I informed Surveyor that hasn't happened but if it did, she would come in to help. Surveyor asked HRA-I if they offer bonuses. HRA-I informed Surveyor they do offer bonuses on emergency needs. HRA-I explained one CNA is not an emergency. Surveyor asked what is considered an emergency. HRA-I explained if they are down 2 or more it is considered an emergency need. Surveyor asked HRA-I to explain how she staffs the vent unit again. HRA-I informed Surveyor if the census is at 15, they keep 2 CNAs. Surveyor asked when the half CNA is added. HRA-I informed Surveyor when the census is at 12 or 13 residents. HRA-I informed Surveyor she doesn't see the need to have two CNAs. For 11 residents she has 1 CNA. HRA-I informed Surveyor when the census is at 14, 15 & up there are two CNAs on the vent unit. Surveyor asked HRA-I if NHA-A increased the staffing on the vent unit. HRA-I replied she did increase the staff, but I utilize them best way I can.On 2/9/26, at 2:14 PM, a Surveyor interviewed Medical Director (MD)-F. Surveyor asked about staffing on the vent unit. MD-F stated the facility does have challenges with hiring and retention like many other facilities. Surveyor asked if staffing one CNA on the vent unit is sufficient enough for a unit with many dependent residents. MD-F stated CNAs can pull from other places in the building for help. MD-F indicated teamwork is key. Surveyor informed MD-F of a continuous observation of 5 hours where multiple residents' needs were not addressed. Surveyor expressed concerns that repositioning needs and cares are not completed timely because there is one CNA on the unit. MD-F stated that MD-F agreed and stated that it is an issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review the facility did not ensure nursing staff working on the ventilator unit had the competency and skill set necessary to care for 13 (R3, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, & R16) of 13 residents who utilize ventilators and/or tracheostomies.Findings include:The facility assessment reviewed February 2026 under the Education and Training section for Registered Nurse (RN), Licensed Practical Nurse (LPN) & Certified Nursing Assistant (CNA) for Competencies Obtained/Evaluated Education Provided documents *Annual Skills checks through Staff Development. *As needed training from vendor, professional group or other for new/unique skill sets required for member care.Surveyor reviewed the facility's daily nursing schedule from 1/11/26 to 2/9/26. The nursing staff on the ventilator unit work 12-hour shifts. Surveyor noted the following nursing staff worked the on the ventilator unit:Licensed Practical Nurse (LPN)-HH on 1/11/26 & 1/13/26.Certified Nursing Assistant (CNA)-K on 1/11/26, 1/15/26, 1/16/26, 1/19/26, 1/20/26, 1/21/26, 1/24/26, 1/25/26, 1/29/26, 2/2/26, 2/3/26, 2/4/26, 2/7/26, & 2/8/26.LPN-JJ on 1/11/26.CNA-KK on 1/11/26, 1/15/26, 1/16/26, 1/19/26, 1/20/26, 1/24/26, 1/25/26, 1/29/26, 1/30/26, 2/2/26, 2/3/26, 2/4/26, & 2/7/26.CNA-LL on 1/11/26, 1/15/26, 1/16/26, 1/19/26, 1/20/26, 1/21/26, 1/24/26, 1/25/26, 1/29/26, 1/30/26, 2/3/26, 2/4/26, 2/7/26, & 2/8/26.LPN-MM on 1/12/26, 1/13/26, 1/14/26, 1/18/26, 1/22/26, 1/26/26, 1/27/26, 1/28/26, 1/31/26, & 2/1/26.CNA-NN on 1/12/26, 1/13/26, 1/17/26, 1/18/26, 1/27/26, 1/28/26, 1/31/26, & 2/1/26.CNA-J on 1/12/26, 1/13/26, 1/14/26, 1/17/26, 1/18/26, 1/22/26, 1/23/26, 1/28/26, 2/5/26, 2/6/26, & 2/9/26.Registered Nurse (RN)-S on 1/12/26.CNA-OO on 1/12/26, 1/13/26, 1/14/26, 1/18/26, 1/23/26, 1/26/26, 1/27/26, 1/28/26, 1/31/26, 2/1/26, 2/5/26, 2/6/26, & 2/9/26.CNA-PP on 1/12/26, 1/13/26, 1/14/26, 1/17/26, 1/18/26, 1/22/26, 1/23/26, 1/26/26, 1/27/26, 1/28/26, 1/31/26, 2/1/26, 2/5/26, 2/6/26, & 2/9/26.CNA-QQ on 1/14/26.LPN-RR on 1/14/26, 1/16/26, 1/17/26, 1/18/26, 1/19/26, 1/20/26, 1/21/26, 1/24/26, 1/25/26, 1/29/26, 1/30/26, 1/31/26, 2/2/26, 2/3/26, 2/4/26, 2/7/26, & 2/8/26.CNA-SS on 1/15/26, 1/19/26, 1/20/26, 1/21/26, 1/24/26, 1/25/26, 1/30/26, 2/2/26, & 2/4/26.CNA-TT on 1/16/26.LPN-UU on 1/22/26, 1/23/26, 1/26/26, 1/27/26, 1/28/26, 2/1/26, 2/5/26, 2/6/26, & 2/9/26.LPN-VV on 1/23/26 & 2/5/26.LPN-WW on 2/5/26.RN-XX on 2/6/26.CNA-YY on 2/8/26.RN-ZZ on 2/9/26.LPN-RR received an in-service dated 3/19/25 for suctioning & trach care. Surveyor noted none of the other staff listed received this in-service. On 2/10/26, at 3:13 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A and Regional Nurse-D Surveyor asked for competencies for facility & agency licensed nurses and certified nursing assistants who worked on the ventilator unit from 1/11/26 to 2/9/26.On 2/10/26, at 8:40 a.m., NHA-A stated to Surveyor we won't have those competencies. We did competencies if something came up, but our policy doesn't reflect we have to do competencies. So, we don't have completed competencies for everyone who worked back there. Surveyor asked for the facility's competency policy.On 2/10/26, at 11:01 a.m., Surveyor was provided with the facility's policy titled, Staffing Designation and Role Assignment and last reviewed 10/21/25 under Purpose documents, To establish a standardized approach for staffing designation and role assignment within the Skilled Nursing Facility (SNF), ensuring staff are appropriately classified according to licensure, certification, education, and job function, reflecting validation beyond regulatory and organizational requirements. Under Procedure documents 1. Designation Upon Hire. Staff are designated based on verified licensure, certification, education, and/or experience. Job titles and roles align with applicable federal, state, and local regulations. 2. Credential Verification. All required licenses, certifications, and credentials are verified prior to assignment and maintained in the personnel file. Staff must maintain current and valid credentials as a condition of employment. 3. Orientation and Training. All staff complete facility orientation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and mandatory in-service education as required by regulation and facility policy. Orientation ensures staff understand facility policies, procedures, and expectations. 4. Role Assignment. Staff perform duties consistent with their designated role and job description. Supervisors ensure assignments remain within the scope of practice and regulatory requirements.On 2/10/26, at 10:37 a.m., Surveyor asked NHA-A how the facility knows staff are competent to work on the ventilator unit if they don't complete competencies for staff. NHA-A replied that's a good question. NHA-A explained they have a formal orientation for every nurse and CNA. NHA-A informed Surveyor if they felt a nurse or CNA was strong enough, they would allow them to explore to work the vent unit. NHA-A informed Surveyor they also take other things into consideration like their past work history such as if they worked in an acute care hospital, they would explore this as well.On 2/10/26, at 1:10 p.m., Surveyor asked NHA-A who is responsible for educating licensed nurses and CNAs. NHA-A informed Surveyor Director of Nursing (DON)-B, Assistant Director of Nursing (ADON)-C or RN-T. Surveyor informed NHA-A Surveyor is aware DON-B is not at the facility and will speak with ADON-C.On 2/10/26, at 1:25 p.m., Surveyor asked ADON-C who in-services nursing staff. ADON-C replied to me, [Name of DON-B] and RN-T. Surveyor asked when do staff receive in-service. ADON-C explained if there is an allegation of abuse, anything new, or if there is a change in order. ADON-C informed Surveyor they just had an in-service for new processes and procedures relating to central supply. Surveyor asked who is responsible for competencies. ADON-C replied that I'm not sure of. Surveyor asked if she had done any. ADON-C replied to no.On 2/10/26, at approximately 2:00 p.m., NHA-A informed Surveyor she was confused when Surveyor spoke to her about competencies. NHA-A informed Surveyor they did competencies about a year ago. Surveyor asked NHA-A to provide Surveyor with competencies for nursing staff who worked on the vent unit. Surveyor did not receive any nursing staff competencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record review, the Facility did not have a full-time DON (Director of Nursing) from 7/22/25 to 10/19/25 and 11/25/25 to date.The facility failed to meet staffing requirements, resulting in the DON having to work as the Clinical Manager/Floor Nurse filling regularly scheduled shifts.This deficient practice had the potential to affect all 65 residents in the facility. Findings include:On 2/4/26 at 12:01 PM, Surveyor received Facility assessment from Nursing Home Administrator (NHA)-A. Surveyor reviewed the Facility Assessment, dated, developed October 2023 and reviewed, January 2026, documents, in part. This document is used to inform staffing decisions to ensure there are a significant number of staff with the appropriate competencies and skill sets necessary to care for its member needs as identified through resident assessments and plans of care. For instance, The Ventilator Unit, staff with a higher staff to member ratio due to increased care needs. Each member care unit is evaluated for need and staffing levels adjusted to meet those needs. Staffing needs are evaluated for all shifts to include AM, PM and night shifts 7 days/week. Staff who are considered to be extra are placed on the unit with greatest need. Nursing Supervisors and scheduling staff have authority to adjust staffing on a consistent basis as a contingency to meet member car needs for non-emergency events that require such. For instance, Facility can reassign licensed nurses, who's primary job is not direct care to assist any unit in direct member care if needed.Facility Assessment Member Profile documents, in part. Facility Capacity/Breakdown: Leadership, Executive Director: NHA-A, DON: Director of Nursing (DON)-B, Ventilator Unit-Lead Nurse: DON-B. Bed Capacity: 87, Average Daily Census: 60.Facility employes a Medical Director and an Infection Preventionist(s) Registered Nurse to ensure compliance with infection prevention and control measures in Facility setting. The infection prevention and control team has established policy and procedure, conducted an Infection Control Risk Assessment as well as developed the Antibiotic Stewardship Program. Facility Wide Totals: DON: 1 FT (Full Time), UM: 1 FT, Lead Nurse RN Vent: 1 FT, MDS (Minimum Data Set) RN: 1 PT (Part Time), RNs (Registered Nurses): 2 FT, 3 PT, LPNs (Licensed Practical Nurses): 6 FT, 5 PT, Respiratory Therapist: 1 FT.On 2/4/26 at 11:30 AM, Surveyor interviewed, Director of Nursing (DON)-B. Surveyor asked DON-B if DON-B works full time as a Director of Nursing. DON-B stated, DON-B works two days per week as a DON and three days a week as the Clinical Manager/Floor Nurse on the vent/trach unit for week one and three days a week as the DON and two days a week as Clinical Manager/Floor Nurse on the vent/trach unit for week 2 in a pay period. DON-B stated DON-B also works every other weekend on the vent/trach unit. DON-B stated DON-B has been the Interim DON since July of 2025 and the Facility is trying to hire someone. Surveyor asked DON-B if DON-B could provide an estimate of how many hours per week DON-B dedicates to DON responsibilities and DON-B stated, 30-32 hours. Surveyor asked who fills in as the DON on the days DON is working as the Clinical Manager and DON-B stated, Assistant Director of Nursing (ADON)-C. On 2/4/26 at 3:15 PM, DON-B stated during the daily exit meeting that DON-B would not be working on the floor tomorrow as tomorrow is one of DON-B's scheduled DON days. On 2/5/26 at 9:09 AM, Surveyor interviewed ADON-C. Surveyor asked ADON-C if ADON-C has any dual roles and ADON-C stated ADON-C occasionally works the floor, but this happened more often in October of 2025. Surveyor asked if ADON-C covers for DON-B and ADON-C stated, ADON-C covers when DON-B is on vacation or when DON-B tells ADON-C to cover when DON-B is working the floor. Surveyor asked if ADON-C is scheduled as the acting DON and ADON stated, no, it is just verbal communication.On 2/5/26 at 1:13 PM, Surveyor interviewed DON-B and asked who if the Facility Infection Preventionist and DON-B stated, that would be me. Surveyor asked DON-B how much time DON-B dedicates to working on infection prevention per week and DON-B stated, every Monday DON-B spends the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	entire day working on infection prevention. DON-B stated, DON-B will multi-task with either DON or Clinical Manager/Floor Nurse responsibilities. On 2/9/26 at 3:30 PM, Surveyor interviewed NHA-A during the exit meeting. NHA-A stated DON-B was also overseeing the entire wound care processes and rounding with Wound MD-R every Monday, in addition to overseeing the LPN providing wound treatments. The only time DON-B was not overseeing wound processes was when DON-W was employed for a very brief time. Surveyor asked NHA-A if there is a plan to hire for the IP and NHA-A stated, no. The plan is to hire a full time DON, transition interim DON-B back to ADON and IP role. Interim ADON-C will then return to a floor nurse.Surveyor notes, DON-B stated DON-B spent every full Monday dedicated to Infection Prevention and NHA-A stated DON-B rounded with Wound MD-R every Monday. This is in addition to splitting DON-B's hours between DON responsibilities and working as the Clinical Manager, dedicated floor nurse in the vent unit.On 2/9/26 at 2:14 PM, Surveyor interviewed Medical Director (MD)-F. Surveyor asked who the Director of Nursing (DON) is at the facility. MD-F stated it was DON-B. MD-F stated that DON-B served as the facility DON in the past and when the facility DON left the job this summer, DON-B stepped in and was being a team player. Surveyor asked if MD-F was aware that DON-B worked part time (50%) on the floor, is serving as DON and is the facility Infection Preventionist (IP). MD-F stated that MD-F was not aware the DON-B was on the floor half of the time. MD-F stated that DON-B had served as IP in the past as well and was qualified.On 2/9/26 at 3:58 PM, Surveyor interviewed Nurse Practitioner (NP)-G, who oversees the respiratory care of residents on the ventilator unit. Surveyor asked if NP-G was aware that Director of Nursing (DON)-B was serving as the DON, working part time (50%) in the ventilator unit and serving as the facility IP. NP-G stated NP-G was not aware. NP-G stated the DON position is typically full time plus more. NP-G indicated that NP-G could understand a concern if the DON has that much on their plate.On 2/9/26 at 9:35 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A what the staffing requirements for a Director of Nursing (DON). NHA-A stated the requirement is that the Facility needs a full-time DON. Surveyor asked if the Facility's DON is full time and NHA-A stated, DON-B works as the DON and works as a floor nurse. Surveyor asked NHA-A if DON -B also works as the Infection Preventionist and NHA-A stated, yes. NHA-A stated the Facility is trying to hire a DON but filling this position has been difficult. NHA-A stated it is not the intent to have DON-B split in so many areas. Surveyor asked NHA-A when DON-B started in the DON role. NHA-A stated DON-B is an interim DON and started in the role in July of 2025 when DON-X resigned employment. In October of 2025, the Facility hired DON-W but DON-W went on a leave of absence in November of 2025 and was terminated December of 2025. After DON-W was terminated, DON-B resumed interim DON role. Surveyor asked NHA-A for the specific dates and timeline.On 2/9/26 at 11:00 AM Surveyor reviewed daily average census of 58.8 for December 2025, 62.3 for January 2026 and 66.0 to date in February 2026.On 2/9/26 at 12:15 PM, NHA-A provided Surveyor timeline for Director of Nursing coverage:6/17/25: Job posted for DON7/21/25: DON-X last day as DON7/22/25: DON-B started as Interim DON (also working as Clinical Manager/Floor Nurse Vent unit, IP, and Wound Supervisor)10/20/25: DON-W started as DON10/20/25: DON-B started as ADON (also working as Clinical Manager/Floor Nurse Vent unit, IP and Wound Supervisor)11/25/25: DON-W went on a Leave of Absence12/11/25: DON-W was terminated12/11/25: Job posted for DON12/11/25: DON-B resumed as Interim DON (also working as Clinical Manager/Floor Nurse Vent unit, IP and Wound Supervisor)On 2/9/26 at 12:31 PM and Surveyor asked NHA-A who covered the DON position from 11/15/25 to 12/11/25 when DON-W went on leave and subsequently terminated. NHA-A stated DON-B stepped in. Surveyor asked NHA-A if DON -B also works as the Infection Preventionist (IP) and NHA-A stated, yes. Surveyor notified NHA-A of the concern that there is not a full-time dedicated DON. Surveyor stated the DON must be full time and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dedicated to DON responsibilities if the census is over 60. The daily average census for January of 2026 was 62.3 and February to date, 2/9/26 is 66. NHA-A expressed understanding.On 2/10/26 at 1:13 PM, Surveyor reviewed staff schedules from 1/11/26 to 2/9/26. DON-B is listed on the schedule for working the vent unit on the following days: 1/15/26, 1/16/26, 1/19/26, 1/20/26, 1/24/26, 1/25/26, 1/29/26, 1/30/26, 2/2/26, 2/3/26, 2/4/26, 2/7/26, & 2/8/26.Surveyor notes, Facility Assessment documents the Facility staffs a full time DON and a full time Ventilator Unit- Lead Nurse, however Facility employs only one full time staff who acts as the DON, Ventilator Unit- Lead Nurse in addition to the Infection Preventionist, Wound Care Supervisor and Lead Educator for the clinical staff. DON-B has several roles that cannot be performed adequately within the hours DON-B is working. This lack of dedication and hours to each role has created a reasonable likelihood for clinical issues discovered at the Facility during this survey.On 2/10/26 at 1:09 PM Surveyor interviewed NHA-A and asked in DON-B was hourly or salaried and NHA-A stated, DON-B is an hourly employee. Surveyor requested the most recent quarter of information submitted to the State for Director of Nursing Hours for the Payroll Based Journal (PBJ) report.On 2/10/26 at 1:32 PM, NHA-A provided Surveyor with DON-B's PBJ reportable hours for July, August and September of 2025. Reportable hours worked per day/per week for DON-B as DON effective 7/22/25 when DON-B became interim DON:7/22/25 (Tu): 12 hours7/23/25 (We): 11.75 hours7/24/25 (Th): 9 hours7/25/25 (Fr): 0 hours7/26/25 (Sa): 11.75 hoursTotal: 44.5 hours7/27/25 (Su): 11.75 hours7/28/25 (Mo): 1.25 hours7/29/25 (Tu): 11.75 hours7/30/25 (We): 11.75 hours7/31/25 (Th): 12 hours8/1/25 (Fr): 11.75 hours8/2/25 (Sa): 0 hoursTotal: 60.25 hours8/3/25 (Su): 0 hours8/4/25(Mo): 12.25 hours8/5/25 (Tu):12.25 hours8/6/25 (We): 12.25 hours8/7/25 (Th):8.75 hours8/8/25 (Fr): 8.5 hours8/9/25 (Sa): 0 hoursTotal: 54 hours8/10/25 (Su): 11.75 hours8/11/25(Mo): 11.25 hours8/12/25 (Tu): 8.75 hours8/13/25 (We): 8.75 hours8/14/25 (Th): 0 hours8/15/25 (Fr): 12 hours8/16/25 (Sa): 2.25 hoursTotal: 54.75 hours8/17/25 (Su): 0 hours8/18/25(Mo): 11.75 hours8/19/25 (Tu): 11.75 hours8/20/25 (We): 11.75 hours8/21/25 (Th): 9 hours8/22/25 (Fr): 0 hours8/23/25 (Sa):11.75 hoursTotal: 56 hours8/24/25 (Su): 11.5 hours8/25/25(Mo): 4.75 hours8/26/25 (Tu): 10.5 hours8/27/25 (We): 2.75 hours8/28/25 (Th): 1.25 hours8/29/25 (Fr): 0 hours8/30/25 (Sa):0 hoursTotal: 30.75 hours8/31/25 (Su): 0 hours9/1/25(Mo): 11.5 hours9/2/25 (Tu): 10.5 hours9/3/25 (We): 8 hours9/4/25 (Th): 6.75 hours9/5/25 (Fr): 0 hours9/6/25 (Sa): 10.75 hoursTotal: 47.5 hours9/7/25 (Su): 11.5 hours9/8/25(Mo): 8.75 hours9/9/25 (Tu): 8 hours9/10/25 (We): 7.75 hours9/11/25 (Th): 0 hours9/12/25 (Fr):10 hours9/13/25 (Sa): 0 hoursTotal: 46 hours9/14/25 (Su): 0 hours9/15/25(Mo): 11.75 hours9/16/25 (Tu): 12.25 hours9/17/25 (We): 10.25 hours9/18/25 (Th): 0 hours9/19/25 (Fr): 8.75 hours9/20/25 (Sa): 11.75 hoursTotal: 54.75 hours9/21/25 (Su): 10.5 hours9/22/25(Mo): 0 hours9/23/25 (Tu): 0 hours9/24/25 (We): 0 hours9/25/25 (Th): 0 hours9/26/25 (Fr): 0 hours9/27/25 (Sa): 0 hoursTotal: 10.5 hoursSurveyor notes, even though most PBJ reportable weeks exceed a 40-hour work week for DON hours, the Facility does not have full time dedicated DON hours Monday through Friday. The reportable hours for many of the days supersede an 8-hour workday with some days working up to 12.25 in one day. Many of the days also include weekend hours for DON coverage and DON-B stated DON-B only works every other weekend as a floor nurse. Also, the PBJ reportable hours does not reflect the actual schedule of what both NHA-A and DON-B stated with DON-B working 3 days DON/2 days Clinical Manager/ Floor Nurse for week 1 and 2 days DON/3 days Clinical Manager/Floor Nurse for week 2, leading to evidence the PBJ reportable hours may not be accurate.On 2/10/26 at 12:47 PM, Surveyor notified NHA-A and Regional Nurse-D regarding the Class B State citation with serious concerns regarding the lack of a full time DON and the likelihood of the lack of a full time dedicated DON, led to the various clinical issues during survey with care planning, infection control, wound care, staffing, tube feeding, catheter care, competencies and other care areas.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility did not ensure the Staffing Data Daily postings were displayed or were accurate to the actual staffing of the facility. This has the potential to affect all 65 of 65 residents currently residing in the facility.*The Facility did not have the Staffing Data Daily posting on 2/4/26 and it was not posted prior to 8:44 AM on 2/9/26.* The Facility does not display the Staffing Data Daily postings on weekends.*The Facility does not maintain copies of the Staffing Data Daily postings.*The Facility does not have the required information documented on the Staffing Data Daily postings. Findings include:On 2/4/26 at 8:45 AM, Surveyor observed no Staffing Data Daily postings at the front desk or anywhere within the Facility. On 2/4/26 at 10:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A where the Staffing Data Daily postings are located and NHA-A stated, there is not one posted for today, 2/4/26 as the Scheduler is not here today. Surveyor asked NHA-A where the staffing data daily posting is typically displayed, and NHA-A showed Surveyor a hallway bulletin board around the corner of the front entrance. On 2/4/26, at 12:01, Surveyor asked NHA-A if Surveyor could have the last 30 days of the Staffing Data Daily postings and NHA-A stated they will be getting back to Surveyor. On 2/4/26 at 12:35 PM. Surveyor interviewed NHA-A and NHA-A stated, To be transparent, I will not be able to provide you with the Staffing Data Daily postings as requested as the Scheduler does not keep the postings after each day. Surveyor notes, Surveyor cannot compare last 30 days of Staffing Data Daily postings to last 30 days of staff schedule due to no evidence of the Staffing Data Daily postings. On 2/5/26 at 8:25 AM, Surveyor observed Staffing Data Daily posting located at the facility entrance front desk and in the hallway on the bulletin board. Staffing Data Daily posting documents, date of 2/5/26, census of 67, AM shift with 4 Licensed Practical Nurses (LPN's), 3 Registered Nurses (RN's) and 8 Certified Nursing Assistant's (CNA's). PM shift with 3 LPN's, 1 RN and 8 CNA's. Night shift with 2 LPN's, 1 Med Tech and 8 CNA's. On call, Director of Nursing (DON)-B with DON-B's phone number. Surveyor notes, on 2/5/26, Staffing Daily Posting did not include Facility name, staff per unit, shift times or actual hours worked and/or total Full Time Equivalents (FTE's). On 2/5/26 at 9:31 AM, Surveyor interviewed Human Resources Assistant (HR Assistant)-I who also works as the Scheduler and Central Supply Clerk. HR Assistant-I's stated their shift typically begins at 6:30 AM to 7:00 AM, Monday through Friday. HR Assistant-I stated the staff work the following shifts and there is always an overlap with beginning and end time for reporting off:Day time shift: 6:00 AM to 2:15 PMEvening shift: 2:00 PM to 10:15 PMNight shift: 10:00 PM to 6:15 AMVent/Trach unit is 12-hour shifts 6:00 AM to 6:15 PM and 6:00 PM to 6:15 AMSurveyor asked HR Assistant-I, what are your minimum staff requirements for day, evening, and night shift and HR Assistant I stated, there are 5 units, east, west, north, rehab, and vent/trach with the following staffing requirements:Day Shift: 8 CNA's, 3 LPN's, 1 RN and there are also the Assistant Director of Nursing (ADON) and DON. HR Assistant-I stated, HR Assistant- I will schedule ADON and DON to cover floor as needed. The east and west unit share 1 RN or LPN. Evening Shift: exact same requirement as day shift. Night Shift: 5 CNA's and 3 LPN's who split the units. HR Assistant-I there is not an RN on night shift, but the DON is always on call who is a registered nurse.Surveyor asked HR Assistant- I how does HR Assistant-I determine staffing. Assistant-I stated, based census, if census is below 60, Scheduler can ask if a CNA wants to have a day off. If census is above 60, current requirement is kept, and staffing does not increase. Surveyor asked HR Assistant-I what the maximum census is, and HR Assistant-I Scheduler stated, that is a good question, I will have to get back to you.Surveyor asked HR Assistant-I where does HR Assistant- I post the Staffing Data Daily posting and HR Assistant-I stated, it is posted by the staff timeclock, bulletin board in hallway on the North/West unit, front desk and vent (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	unit. Surveyor verified posting was in all locations. Surveyor asked HR Assistant-I how often does HR Assistant post and HR Assistant-I stated HR Assistant-I will post first thing in the morning at approximately 6:30 AM and make written changes on post if there is a census change. If there is a call in and not replaced, then Scheduler makes a written update on positing. Scheduler asked HR Assistant-I how long HR Assistant keeps the Staffing Data Daily postings and HR Assistant-I stated HR Assistant-I does not keep postings and shreds postings every day. Surveyor asked HR Assistant-I who covers for HR Assistant-I when HR Assistant-I is not at work and HR Assistant-I stated NHA-A will cover when HR Assistant-I calls off work. HR Assistant-I stated, HR Assistant-I has not had a vacation since HR Assistant-I started at the Facility so when that occurs, HR Assistant- I will review with NHA-A for a plan.On 2/5/26 at 10:37 AM, HR Assistant-I informed Surveyor the Facility maximum census is 87.On 2/9/26 at 8:07 AM, Surveyor observed Staffing Data Daily posting located in the hallway, front desk and time clock area to be dated 2/6/26. This outdated posting is from last Friday. There was not any posting over the weekend to include 2/7/26 and 2/8/26. The posting from 2/6/26 does not include Facility name, total hours worked or FTE per shift. On 2/9/26 at 8:44 AM, Surveyor observed no evidence of an updated Staffing Data Daily posting for the day. The outdated posting for 2/6/26 was still in all locations indicated. On 2/9/26 at 9:11 AM, Surveyor observed updated staffing data daily posting for 2/9/26. Posting does not include Facility name, total hours worked per shift or FTE per shift. On 2/9/26 at 9:36 AM Surveyor asked HR Assistant-I who is responsible for the Staffing Data Daily postings on the weekend and HR Assistant -I Scheduler stated HR Assistant-I does not know but will find out.On 2/9/26 at 9:47 AM, Surveyor interviewed NHA-A. Surveyor asked NHA-A if there are any policies and procedures regarding Staffing Data Daily posting and NHA-A stated, no. Surveyor asked NHA-A what the components are to be included in the Staffing Data Daily posting and NHA-A stated, the posting needs to include date, census and number of Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses. Surveyor asked who is responsible for posting the staffing data daily posting on the weekends and NHA-A stated, no one is responsible right now. Surveyor notified NHA-A of concerns with missing postings. Surveyor notified NHA-A that in addition to what NHA-A mentioned for components of the posting, the Staffing Data Daily posting also needs to include, Facility name, number of Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses along with a corresponding number of actual hours and/or FTE equivalent. Surveyor also notified NHA-A of concern regarding missing post on 2/4/26 and no record of the staffing data daily posting for the past 18 months. NHA-A expressed understanding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 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 interview and record review the facility did not ensure 1 (R1) of 2 residents reviewed for medications were provided pharmaceutical services to meet the needs of the resident. R1 was admitted to the facility on [DATE] and did not receive multiple scheduled medications in January 2026 and February 2026, did not receive as needed (PRN) Hydralazine as ordered for elevated blood pressure (BP), and did not receive multiple scheduled BP checks in January 2026 and February 2026. Findings include: The facility's policy titled Medication Orders, dated 8/2/22, last reviewed 10/21/25, documents:The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders.A current list of orders must be maintained in the clinical record of each resident.Orders must be written and maintained in chronological order.Physician Orders/Progress Notes must be signed and dated every thirty (30) days.Recording Orders:Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered.As Needed (PRN) Medication Orders - When recording PRN medication orders, specify the type, route, dosage, frequency, strength and the reason for administration.Treatment Orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment. R1 was admitted to the facility on [DATE]. R1 was hospitalized [DATE] - 1/9/26 due to left cerebellar intracranial hemorrhage (a critical life-threatening medical emergency involving bleeding inside the skull which can rapidly destroy brain cells by causing pressure and oxygen deprivation). R1's diagnoses include intracranial hemorrhage, dysphagia (difficulty swallowing), morbid obesity, atrial fibrillation (irregular heartrate), heart disease, transient ischemic attack (TIA) (temporary blockage of blood flow to the brain), Parkinson's disease (a disorder that occurs when nerve cells in the brain die or become damaged), and cognitive impairment (decline in mental abilities). R1's admission Minimum Data Set (MDS) completed on 1/21/26, documents R1 used a walker and manual wheelchair. R1 requires substantial/maximal assistance with bathing, dressing, and rolling left to right. R1 is dependent on staff for toileting hygiene. R1 was assessed as having a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. Surveyor reviewed R1's physician orders and notes the following:-Amlodipine 10 mg (milligrams) by mouth once daily for hypertension (high blood pressure) (ordered on 1/10/26, at 8:00 AM).-Atorvastatin 80 mg by mouth once daily at bedtime for hyperlipidemia (high cholesterol) (ordered on 1/9/26, at 8:00 PM).-Melatonin 3 mg by mouth at bedtime for insomnia (trouble sleeping) (ordered on 1/9/26, at 8:00 PM).-Polyethylene Glycol 3350 Powder. Give 17 grams by mouth in the morning for constipation (ordered on 1/10/26, at 8:00 AM).-Trazadone 150 mg tablet. Give 75 mg (0.5 tablet) by mouth at bedtime for depression (ordered on 1/9/26, at 8:00 PM).-Amantadine 100 mg table. Give one tablet by mouth two times a day for Parkinson's Disease (ordered on 1/10/26, at 8:00 AM).-Carvedilol 25 mg tablet. Give one tablet by mouth two times a day for hypertension (ordered on 1/9/26, at 8:00 PM).-Eliquis 5 mg tablet. Give one tablet by mouth two times a day for atrial fibrillation (irregular heartbeat) (ordered on 1/29/26, at 8:00 PM).-Lisinopril 20 mg tablet. Give one tablet by mouth every morning and at bedtime for hypertension (ordered on 1/9/26, at 8:00 PM).-Sennosides 8.6 mg tablet. Give two tablets by mouth two times a day for constipation (ordered on 1/9/26, at 8:00 PM).-Check Blood Pressure and Heart Rate (BP/HR) three times daily at every shift due to recent Intracerebral Hemorrhage (ICH) (stroke) (ordered on 1/15/26, at 2:00 PM).-Hydralazine 25 mg tablet. Give 25 mg by mouth every 8 hours as needed for Systolic Blood Pressure (SBP) > 175 (ordered on 1/9/26, at 6:00 PM, discontinued on 1/14/26, at 10:15 AM).-Hydralazine 25 mg tablet. Give one tablet by mouth every 8 hours for hypertension. Hold for SBP less than 130 (ordered on 1/14/26, at 4:00 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, discontinued on 1/29/26, at 6:31 AM).-Hydralazine 25 mg tablet. Given 1 tablet by mouth every 8 hours as needed for SBP 175 or greater (ordered on 1/29/26, at 6:45 AM). Surveyor reviewed R1's Medication Administration Record (MAR) and notes R1 did not receive the following number of scheduled medications as ordered:-Six (6) scheduled medications on 1/9/26-Two (2) scheduled medications on 1/10/26-Seven (7) scheduled medications on 1/16/26-Seven (7) scheduled medications on 1/17/26-Seven (7) scheduled medications on 1/18/26-One (1) scheduled medication on 1/19/26-Seven (7) scheduled medications on 1/21/26-Eight (8) scheduled medications on 1/22/26-Seven (7) scheduled medications on 1/23/26-Eight (8) scheduled medications on 1/24/26-Seven (7) scheduled medications on 1/25/26-Eight (8) scheduled medications on 1/30/26-Seven (7) scheduled medications on 1/31/26-Seven (7) scheduled medications on 2/6/26 Surveyor notes the missed scheduled medications include Amlodipine, Atorvastatin, Melatonin, Polyethylene Glycol powder, Trazadone, Amantadine, Carvedilol, Eliquis, Lisinopril, Sennosides, and Hydralazine. Surveyor notes R1 was documented as having a SBP > 175 on 2/2/26, at 10:17 AM, with no PRN Hydralazine administered. Surveyor notes R1 received Hydralazine with a SBP < 130 (with orders to hold if SBP < 130 on 1/14/26 - 1/29/26) on the following dates:1/16/26 at 4:00 PM1/22/26 at 4:00 PM1/24/26 at 12:00 AM1/25/26 at 8:00 AM1/25/26 at 4:00 PM1/26/26 at 4:00 PM Surveyor reviewed R1's Blood Pressure Log and blood pressure readings on R1's MAR for January 2026 and February 2026, and notes the following missed blood pressure entries:-Two (2) missed BP readings on 1/11/26-Two (2) missed BP readings on 1/12/26-Two (2) missed BP readings on 1/13/26-One (1) missed BP reading on 1/14/26-One (1) missed BP reading on 1/15/26-One (1) missed BP reading on 1/16/26-Two (2) missed BP readings on 1/18/26-One (1) missed BP reading on 1/20/26-Two (2) missed BP readings on 1/21/26-One (1) missed BP reading on 1/23/26-One (1) missed BP reading on 1/24/26-One (1) missed BP reading on 1/25/26-One (1) missed BP reading on 1/28/26-One (1) missed BP reading on 1/29/26-Three (3) missed BP readings on 1/30/26-Three (3) missed BP readings on 1/31/26-Three (3) missed BP readings on 2/1/26-One (1) missed BP reading on 2/2/26-One (1) missed BP reading on 2/3/26-One (1) missed BP reading on 2/4/26-One (1) missed BP reading on 2/5/26-Two (2) missed BP readings on 2/6/26-Two (2) missed BP readings on 2/7/26-One (1) missed BP reading on 2/8/26 On 2/3/26, at 11:51 AM, Surveyor interviewed R1 who states R1 does not always receive scheduled medications and did not receive medications on day of admission on [DATE]. On 2/9/26, at 9:36 AM, Surveyor interviewed R1 who states the facility is missing blood pressure checks and has not received some scheduled blood pressure medications. R1 was unable to relay to Surveyor exact dates and times of missed medications but expressed concern with frequent missed medications. On 2/5/26, at 1:06 PM, Surveyor interviewed Nurse Practitioner (NP)-FF who states she will review R1's blood pressure (BP) readings and has made active medication changes based on BP readings. Surveyor asked about R1's BP readings and NP-FF states R1 was given a BP machine to keep in R1's room. R1's BP machine will document BP readings on R1's personal cell phone for R1 to monitor and NP-FF will check R1's phone for BP readings. NP-FF reviewed BP goals for R1 with Surveyor. NP-FF states she was not aware of any concerns from R1's family or the facility about medications or BP concerns. On 2/5/26, at 1:16 PM, Surveyor interviewed R1 who showed Surveyor R1's BP readings in R1's personal mobile phone and R1 notes to Surveyor many days with 1-2 BP readings. R1 notified Surveyor R1's BP is to be checked 3 times a day. Surveyor noted R1's BP machine on R1's bedside table out of reach from R1. R1 states NP-FF provided a BP machine to R1 about 2 weeks ago and R1 will ask the nurses to do R1's BP every time the nurse is administering medications. R1 states R1 is unable to perform BP check on their own and requires assistance from facility staff. On 2/9/26, at 11:32 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-GG who indicates she is not familiar with R1. LPN-GG states the nurse will document in the MAR or a progress note if a resident declines a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication or is unavailable to administer a medication. LPN-GG opened the unit's medication cart and showed Surveyor, R1's medication bubble pack for Trazadone as an example. LPN-GG noted to Surveyor that there is no way of knowing if a resident missed a medication by looking at the bubble pack, as staff go down to the next medication/bubble to dispense the next dose and the opened bubbles/medications do not coincide with the number/date listed on the side. On 2/9/26, at 12:50 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who states staff are to document in the MAR or a progress note if a resident declines a medication or is unavailable for the nurse to administer a medication. ADON-C states there is no way of knowing if a medication was not administered by looking at the bubble packs. ADON-C states if a medication is declined by a resident and the nurse documents this in the MAR, it will trigger a MAR progress note in the resident's Electronic Medical Record (EMR). ADON-C states nursing staff are responsible for and expected to know scheduled and PRN medications and when to administer at prescribed times and per the order. Surveyor reviewed R1's MAR for January 2026, MAR for February 2026, and BP readings with ADON-C and noted the missed entries documented above. ADON-C states she was asked to print out information for the Surveyor and noted multiple missed entries on R1's MARs and BP logs. Surveyor also noted to ADON-C, no PRN Hydralazine given per order recommendations to administer when SBP > 175. ADON-C acknowledged these concerns and states she didn't have an explanation as to why they were missed. On 2/9/26, at 3:12 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Regional Nurse-D of the following concerns:R1 did not receive medications on 1/9/26 on day of admission.R1 had multiple missed scheduled and PRN medications.R1 had multiple missed BP checks.NHA-A and Regional Nurse-D acknowledged these concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure therapy services were provided in a timely manner for 2 (R1 and R2) of 2 residents reviewed for therapy services. *R1 was admitted to the facility on [DATE] for rehabilitation after hospitalization for intracranial hemorrhage requiring Physical Therapy (PT). R1 did not start PT until 1/12/26. *R2 was admitted on [DATE] for rehabilitation. R2 did not receive physical therapy services until 1/8/26. R2 was discharged to the hospital on 1/12/26 and received only 2 physical therapy sessions. Findings include: The facility's policy titled Therapy Services, that is not dated, documents the following: Facility will schedule and conduct therapy evaluations and services in accordance with the resident's treatment plan and Medicare guidelines. The therapist shall interview the resident and consult with the attending physician as to the type of treatment to be administered. Therapy is scheduled in coordination with nursing service and is documented in the resident's medical records. Specialized rehabilitative services include physical therapy, speech pathology/audiology, and occupational therapy. R1 was admitted to the facility on [DATE], with diagnosis that includes intracerebral hemorrhage (life-threatening type of stroke caused by a ruptured blood vessel), dysphagia (difficulty swallowing), morbid obesity (chronic health condition defined by a body mass index of 40 or higher), atrial fibrillation (irregular heart rate), heart disease (a condition affecting the heart's pumping function and structure), neurogenic bowel (loss of normal bowel control and function), neuromuscular dysfunction of bladder (lack of bladder control due to brain problems), chronic kidney disease (kidneys are damaged and unable to properly filter waste and extra water from the blood), edema (swelling caused by excess fluid), Transient Ischemic Attack (TIA) (a temporary blockage of blood flow to the brain that causes stroke-like symptoms), and cognitive impairment (limitations in mental functioning, including difficulties with memory, thinking, language, judgment, and learning). R1's admission Minimum Data Set (MDS) completed on 1/21/26, documents R1 uses a walker and manual wheelchair. R1 requires substantial/maximal assistance with bathing, dressing, and rolling left to right. R1 is dependent on staff for toileting hygiene. R1 requires set-up assistance for eating and oral hygiene. R1 was documented as having a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1's Care Area Assessments (CAA) documents the following: Functional Abilities CAA – R1 requires staff to provide assistance with thorough completion of Activities of Daily Living (ADL)s due to physical limitations from acute health conditions. R1 is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	currently working with therapy for increased independence with ADLs. Staff are to provide assistance to meet R1's ADL needs. Staff are to monitor and update MD as needed with changes in condition that requires change to plan of care. R1's care plan, dated 1/9/26, documents: R1 uses a safety device wheelchair for mobility related to impaired ambulation (date initiated 1/29/26). Interventions include: A safety device review will be completed upon implementation of a device, annually and with any major change in condition (date initiated 1/29/26). An annual consent reviewing the risks and benefits of the device will be reviewed and signed by myself or my responsible party (date initiated 1/29/26). Once the device is implemented, staff will review and document for three days if any signs of physical or mental distress are present (date initiated 1/29/26). R1's Electronic Medical Record (EMR) documents the following: Facility Therapy to Nursing Recommendations Form completed on 1/12/26. R1 requires a raised toilet seat and standard wheelchair. R1 requires assistance from two staff members with a bariatric walker or transfers. Comments include: Unable to assess functional transfer of this date. Updated provided with R1 is able to transfer with assistance of two staff members and a walker. Surveyor notes that therapy recommendations to nursing staff were completed on 1/12/26 (day 4 after admission into the facility). On 2/9/26, at 9:36 AM, Surveyor interviewed R1. Surveyor notes a bariatric wheelchair and bariatric walker present in R1's room. R1 stated the facility did not evaluate R1 until multiple days after being admitted to the facility. R1 states it took the facility 5 days to get a bariatric walker and a couple days to get a bariatric wheelchair. R1 states facility staff made R1 use the urinal while lying in bed and have bowel movements in R1's bed, due to staff not knowing how R1 ambulates or transfers until therapy was able to evaluate R1. R1 states R1 laid in bed all weekend until therapy was available on the following Monday 1/12/26, for R1's therapy evaluation. On 2/4/26, at 8:57 AM, Surveyor interviewed Director of Rehabilitation (DOR)-U who states the facility does not have a full time Physical Therapist (PT). Currently the facility is employing as needed (PRN) staff with coverage 3 days a week. The facility has 2 full-time Physical Therapy Assistants (PTA). DOR-U indicates PT will focus on core strength, transferring and bed mobility for residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DOR-U indicates the goal is to evaluate a resident on the day of admission, or the following day. Surveyor asked DOR-U if the facility has therapy staff to evaluate new residents admitted on Friday, Saturday, or Sunday. DOR-U replied weekend staff are present for residents admitted on a Friday. DOR-U then stated everyone struggles with staffing. DOR-U stated R1 had a delay in therapy due to the facility confirming if R1's insurance was covered. Surveyor asked DOR-U if insurance coverage is confirmed prior to a resident admitting to the facility for Subacute Rehabilitation (SAR) and DOR-U replied it was her first week working with a new computer portal system for verification benefits. Surveyor notified DOR-U of concerns with R1's therapy being delayed and the facility did not have insurance coverage verification as to whether R1's insurance covered therapy services at the facility. On 2/4/26, at 9:26 AM, DOR-U and Nursing Home Administrator (NHA)-A requested to speak with Surveyor and notified Surveyor R1 had Occupational Therapy (OT) on 1/11/26 and Physical Therapy (PT) evaluated R1 on 1/12/26. DOR-U and NHA-A stated staffing is also an issue and a deficit. Surveyor notified DOR-U and NHA-A of concerns with R1's therapy being delayed as evidence by, PT evaluating R1 on 1/12/26 and staff's inability to transfer R1 out of bed until PT evaluated, and the facility did not have insurance coverage verification as to whether R1's insurance covered therapy services at the facility. DOR-U and NHA-A acknowledged these concerns. 2.) R2 was admitted to the facility on [DATE] with diagnoses of hepatic encephalopathy, alcohol cirrhosis of liver with ascites and pancreatic cancer. The admission minimum data set (MDS) dated [DATE] documents R2 is cognitively intact and needs moderate assistance with bathing, dressing and bed mobility. Surveyor reviewed R2 physical therapy evaluation and plan of treatment documentation. R2 was screened on 1/6/26, by physical therapy to need a standard wheelchair and a two wheeled walker with assistance of one staff for transfers. The physical therapy evaluation and plan of treatment dated 1/8/26 documents treatment approaches for R2. The treatment approaches are therapeutic exercises, neuromuscular reeducation, gait training therapy, group therapeutic procedures, physical therapy evaluation: moderate complexity, therapeutic activities and wheelchair management training. Therapy frequency of five times a week for four weeks. The only documented physical therapy days completed for R2 were on 1/8/26 and 1/9/26. On 2/4/26 at 9:00 a.m., Surveyor interviewed Director of Rehab-U. Surveyor asked Director of Rehab-U, why did R2's therapy started 3 days after admission. Director of Rehab-U stated there was a gap in staffing the physical therapy department. Director or Rehab-U stated she couldn't get a physical therapist to come into the building to provide physical therapy. Director of Rehab-U stated this was communicated to R2's daughter. On 2/9/26 at 3:15 p.m., during the daily exit meeting with Nursing Home Administrator (NHA)-A, Surveyor explained the concern R2 was admitted on [DATE] for rehabilitation and physical therapy did not begin until 3 days after admission due to staffing concerns with therapy. NHA-A had no additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 7 (R13, R10, R3, R6, R5, R12, & R7) of 7 residents.* Staff did not wear appropriate PPE (personal protective equipment) when administering R13's medication via the feeding tube and providing personal cares on 2/5/26. R13 is on EBP (enhanced barrier precautions).*Staff did not wear appropriate PPE when suctioning R10 and during therapy on 2/5/26. R10 is on EBP.*Staff did not wear appropriate PPE when repositioning R3 on 2/5/26. R3 is on EBP and contact isolation.*There is no EBP sign posted outside R6's room and staff did not wear appropriate PPE when transferring R6 from the Broda chair into bed on 2/5/26. *Staff did not wear appropriate PPE (personal protective equipment) when providing incontinent cares for R5, R12, & R7. R5, R12, & R7 are on EBP (enhanced barrier precautions).Findings include:The facility's policy titled, Enhanced Barrier Precautions and dated 3/25/24 under policy documents It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Under Definitions documents Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves during high contact resident care activities. Under Policy Explanation and Compliance Guidelines: documents 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities (described below) and may not need to be donned prior to entering the resident's room. 4. High-Contact resident care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy ventilator tubes. h. Wound care: any chronic skin opening requiring a dressing.1.) R13's diagnosis includes amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease that destroys motor neurons in the brain and spinal cord leading to severe muscle weakness, paralysis and eventually respiratory failure). R13 is dependent on a ventilator, has a tracheostomy and receives medication & nutrition via a feeding tube.R13's care plan documents, at risk for multidrug-resistant organism transmission during high contact care activities requiring enhanced barrier precautions related to tube feeding, vent status initiated and revised on 10/29/25 documents interventions of *PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High contact includes: Dressing, Bathing/showering, Transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any chronic skin opening requiring a dressing. Initiated 10/29/25.On 2/5/26, at 9:01 a.m., Surveyor observed on the door frame of R13's room there is an EBP sign. Surveyor observed Licensed Practical Nurse (LPN)-BB in R13's room wearing a mask and gloves. LPN-BB was not wearing a gown. Surveyor observed LPN-BB had a syringe in R13's feeding tube.On 2/5/26, at 9:07 a.m., Surveyor observed LPN-BB leave R13's room. Surveyor asked LPN-BB if she was administering R13's medication via the feeding tube. LPN-BB replied yes. Surveyor noted LPN-BB was not wearing appropriate PPE for R13 who is on EBP.On 2/5/26, at 11:11 a.m., Surveyor observed Certified Nursing Assistant (CNA)-J stated I have to go back to [first name of R13]. Surveyor asked CNA-J what she was going to do. CNA-J informed Surveyor she's going to change her. CNA-J brought a soiled linen cart (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	over to R13's door and placed gloves on. Surveyor noted there is a PPE (personal protective equipment) container on R13's door. CNA-J did not place a gown on. CNA-J removed the bedding off R13 and then left R13's room with her gloves on. CNA-J walked down to the clean linen cart, removed linen from the cart, went to R13's room and shut the door. Surveyor observed CNA-J did not remove a gown from the PPE container or place a gown on. 2.) R10's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear and nervousness that can interfere with daily life), and major depressive disorder (a serious common mental health condition characterized by a persistent intense and low mood along with a loss of interest in activities. R10 has a feeding tube, tracheostomy and is on a ventilator.On 2/5/26, at 9:18 a.m., Surveyor observed an EBP (enhanced barrier precaution sign) outside R10's room.On 2/5/26, at 9:19 a.m., Surveyor observed Licensed Practical Nurse (LPN)-BB in R10's room suctioning R10. Surveyor observed LPN-BB is wearing a mask and gloves. LPN-BB is not wearing a gown. Surveyor observed that while LPN-BB was suctioning R10, LPN-BB asked R10 if she got it all. Surveyor noted LPN-BB is not wearing appropriate PPE for R10 who is on EBP.On 2/5/26, at 10:29 a.m., Surveyor observed PTA (Physical Therapy Assistant)-CC and Certified Nursing Assistant (CNA)-J enter R10's room wearing only gloves. Neither PTA-CC or CNA-J were wearing a gown. PTA-CC stated to R10 going to have you sit on the edge of the bed. PTA-CC then asked R10 if she could swing her legs over. PTA-CC then moved R10's legs assisting R10 to sit on the edge of the bed. At 10:37 a.m. CNA-J left R10's room while PTA-CC continued to provide therapy to R10. Surveyor observed PTA-CC was not wearing appropriate PPE while providing therapy to R10 who is on enhanced barrier precaution.3.) R3's diagnoses include anoxic brain damage (brain is deprived of oxygen leading to cell death), acute & chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), and dysphagia (difficulty swallowing). R3 has a feeding tube, indwelling urinary catheter, tracheostomy and is on a ventilator.On 2/5/26, at 10:10 a.m., Surveyor observed outside R3's door there are two isolation signs, an enhanced barrier precaution sign and a contact isolation sign. Surveyor observed Certified Nursing Assistant (CNA)-J entered R3's room and did not close R3's door. Surveyor observed that CNA-J is not wearing gloves or a gown. At 10:11 a.m., CNA-J removed the bedding off R3 and pillows from under R3's left and right side. CNA-J repositioned R3 to the right side of the bed by pulling on the draw sheet which was under R3. CNA-J placed a pillow under R3's right side and then a pillow under R3's left upper side. CNA-J covered R3 with bedding, raised the height of the bed and placed the call light in reach. At 10:14 a.m. CNA-J went into the bathroom and washed her hands. Surveyor noted during this observation, CNA-J was not wearing appropriate PPE (personal protective equipment).4.) R6's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), dysphagia (difficulty swallowing), anxiety disorder (group of mental health conditions characterized by excessive and persistent worry), and encephalopathy (general brain dysfunction characterized by alteration in brain function or structure). R6 has a gastrostomy tube, tracheostomy and is on a ventilator.On 2/5/26, at 11:34 a.m., Surveyor observed R6 has a PPE (personal protective equipment) container on the door but there is no enhance barrier precaution sign posted on or around R6's door.On 2/5/26, at 11:37 a.m., Surveyor observed Certified Nursing Assistant (CNA)-J wheeling R6 down the hallway with PTA (Physical Therapy Assistant)-CC and RT (Respiratory Therapist)-DD into R6's room. After wheeling R6 into her room, CNA-J left the room and returned with a Hoyer lift. On 2/5/26, at 11:39 a.m. Surveyor entered R6's room and observed CNA-J and PTA-CC in the process of attaching the sling which was under R6 to the Hoyer lift. Surveyor observed CNA-J, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PTA-CC and RT-DD were only wearing gloves. Surveyor introduced self and asked permission to observe staff transfer her into bed. R6 shook her head no and Surveyor left R6's room. On 2/5/26, at approximately 12:01 p.m., Surveyor observed R6 in bed.5.) R5's diagnoses include anoxic brain damage (brain is deprived of oxygen leading to cell death), dysphagia (difficulty swallowing), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), and quadriplegia (paralysis of all four limbs). R5 has a feeding tube and tracheostomy.On 2/5/26, at 12:27 p.m., Surveyor observed Certified Nursing Assistant (CNA)-J rolled a linen cart to outside R5's room. Surveyor observed there is an enhanced barrier sign outside R5's room and a PPE cart.On 2/5/26, at 12:30 p.m., Surveyor observed CNA-J place gloves on and entered R5's room. CNA-J did not place a gown on. CNA-J stated to R5 boyfriend look at this face here. CNA-J lowered R5's head of the bed flat and removed R5's gown. At 12:33 p.m. Respiratory Therapist (RT)-DD entered R5's room. CNA-J asked RT-DD to check R5's trach collar as she thought it was too loose. RT-DD tightened R5's trach collar and then left R5's room. CNA-J gathered her supplies. CNA-J washed R5's face, upper body, shut R5's room door, removed her gloves and washed her hands. CNA-J placed gloves on, unfastened R5's saturated product, and washed R5's frontal area removing bowel movement. CNA-J positioned R5 on the right side and washed R5's buttocks to remove bowel movement. CNA-J folded the draw sheet as the sheet became soiled with stool. At 12:43 p.m. CNA-EE entered R5's room, CNA-J asked CNA-EE if she could get her a draw sheet which CNA-EE did. Surveyor observed that CNA-EE has only gloves on and is not wearing a gown. CNA-EE positioned R5 from side to side while CNA-J removed soiled items, placed a new draw sheet on R5's bed and incontinent product on. CNA-EE placed soiled items in bag, removed gloves, and washed her hands. CNA-EE place gloves on and a gown was placed on R5. CNA-J raised the feet portion & head of the bed up and lowered the bed down. CNA-J placed pillows under R5's arms, restarted R5's tube feeding and stated she was going to wash her hands. Surveyor noted during this incontinence observation neither CNA-J nor CNA-EE were wearing appropriate PPE.6.) R12's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), and dysphagia (difficulty swallowing). R12 has a feeding tube and tracheostomy.On 2/5/26, at 12:57 p.m., Certified Nursing Assistant (CNA)-J informed Surveyor she was going to do, referring to incontinent cares, for R12. CNA-J wheeled the linen cart over to R12's room, placed gloves on, and entered R12's room. Surveyor did not observe CNA-J place a gown on. Surveyor observed that there is an enhanced barrier precaution sign outside R12's room and a PPE (personal protective equipment) cart.On 2/5/26, at 1:01 p.m., Surveyor observed CNA-J open R12's door and remove linen from the cart. Surveyor observed that CNA-J is only wearing gloves and does not have a gown on.7.) R7's diagnoses includes myotonic muscular dystrophy (multisystem genetic disorder characterized by progressive muscle wasting, weakness, and delayed relaxation), chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide) with hypoxia (low levels of oxygen), dysphagia (difficulty swallowing), and anxiety disorder (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating). R7 has a feeding tube, tracheostomy, and is on a ventilator.R7's at risk for multidrug-resistant organism transmission during high contact car activities requiring enhanced barrier precautions related to tube feeding, tracheostomy, vent status care plan initiated and revised on 10/29/25 includes an intervention of PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities and ay not need to be donned prior to entering the resident's room. High contact includes: Dressing, Bathing/showering, Transferring, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525498	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Providing hygiene care, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any chronic skin opening requiring a dressing. Initiated 10/29/25.On 2/5/26, at 1:18 p.m. Surveyor entered R7's room with Certified Nursing Assistant (CNA)-J who had placed gloves on. Surveyor observed prior to entering R7's room there is an enhanced barrier precaution sign outside R7's door and a PPE (personal protective equipment) container on the door. Surveyor introduced self and asked permission to observe cares. R7 shook her head yes. CNA-J placed R7's tube feeding on hold, lowered the head of the bed flat, and removed R7's bedding. CNA-J unfastened R7's incontinence product which was saturated with dark yellow urine. CNA-J moved the garbage can over to the side of the bed and using a disposable wipe, wiped R7's inner thighs and frontal perineal area from front to back. CNA-J pulled R7 to the left side of the bed and rolled R7 onto her right side. Surveyor observed a large amount of stool in R7's rectal area and on R7's buttocks. CNA-J wiped R7 with the incontinence product and removed the incontinence product. Surveyor observed the sheet under R7 is wet with urine. CNA-J indicated she is going to have to change the sheets. CNA-J wiped R7's rectal area and buttocks with a disposable wipe and R7 was positioned on her back. CNA-J removed her gloves, went to the linen cart for a sheet and placed gloves on. CNA-J removed the soiled fitted sheet on the right side and placed a clean fitted sheet on. R7 was positioned on the side, barrier cream was applied and a product placed under R7. R7 was positioned on the left side, CNA-J removed the soiled sheet, placed the fitted sheet on the other side of the bed, and fastened R7's incontinence product. R7 was covered with a sheet & blanket. During this incontinence care observation CNA-J did not wear the appropriate PPE as she was not wearing a gown.On 2/9/26, at 2:20 p.m., Surveyor asked Assistant Director of Nursing (ADON)-C how staff are aware a resident is on enhanced barrier precaution or isolation. ADON-C informed Surveyor there is a sign outside the door. Surveyor asked ADON-C if all the residents on the vent unit are on enhanced barrier precautions. ADON-C replied that I'm not sure of and explained when [first name of Director of Nursing-B] is here they separate SNF (skilled nursing facility) & rehab and the vents. DON-B is over the vents. Surveyor was unable to interview DON-B, who is the infection preventionist, as she was not at the facility on 2/9/26 & 2/10/26. Surveyor asked ADON-C if a resident is on enhanced barrier precaution what should staff wear when providing cares. ADON-C replied technically gloves and explained unless there is actual care given. Surveyor asked ADON-C what actual cares are. ADON-C informed Surveyor brushing teeth, grooming, bathing, dressing, and incontinence care. Surveyor asked if they were transferring a resident should they wear a gown. ADON-C replied yes. Surveyor asked ADON-C when staff would only wear gloves. ADON-C informed Surveyor when they are delivering food. Surveyor informed ADON-C of the observations of staff on the vent unit not wearing the appropriate PPE and did not observe staff wearing gowns.