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	04/14/2026

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** Uncorrected on revisitBased on interview and record review, the facility did not ensure 1 (R88) of 9 sampled residents received treatment and care in accordance with physician/nurse practitioner orders.*R88's NP requested R88 have daily weight monitoring beginning 3/24/26, and the facility did not implement daily weight monitoring until 4/3/26. Findings include:R88 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, chronic kidney disease, and chronic diastolic (congestive) heart failure (a chronic condition when the heart cannot pump blood efficiently leading to blood backing up and fluid buildup in the lungs, legs, and body). R88's admission MDS dated [DATE] documents a BIMS score of 15 indicating intact cognition. A progress note in R88's EHR dated 3/24/26 written by Nurse Practitioner (NP)-D documents chronic diastolic (congestive) heart failure - monitor daily weights . follow up: continue daily weight monitoring. Surveyor reviewed R88's EHR and located the following weights:3/20/26 335.0 pounds4/3/26 332.8 pounds4/4/26 332.1 pounds4/7/26 333.0 pounds4/8/26 333.2 pounds4/9/26 332.8 pounds4/10/26 331.0 pounds4/11/26 333.0 pounds4/12/26 333.0 pounds4/13/26 334.7 poundsR88's physician orders document daily weight every, day shift with order date 4/2/26 and start date 4/3/26. Surveyor was unable to locate any evidence in R88's EHR that R88 was weighed daily between 3/24/26 and 4/3/26. In an interview on 4/14/26 at 11:55 AM, Director of Nursing (DON)-B stated if the NP makes any recommendations after seeing a resident, these recommendations are given verbally or in writing to the unit nurse manager on the floor. DON-B stated if the NP requested a resident be weighed daily, daily weights should be initiated within 24 hours of the NP's request. Surveyor shared concern with DON-B that R88's NP requested R88 be weighed daily starting 3/24/26 and the facility did not begin weighing R88 daily until 4/3/26. No additional information was provided. In an interview on 4/14/26 at 1:00 PM, NP-D stated if NP-D has a recommendation or new order after seeing a resident, NP-D notifies DON-B or one of the nurses at the facility. NP-D stated if NP-D recommends a resident is weighed daily, NP-D would expect the facility to begin daily weights by the following day. On 4/14/26 at 1:56 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R10's NP (D) requested R88 be weighed daily starting 3/24/26 and Surveyor was unable to locate any evidence the facility completed this request until 4/3/26.

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: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Amethyst Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Uncorrected on revisit Based on observation, record review and staff interviews, the facility did not ensure they provided necessary treatment and services in accordance with standards of practice to 3 out of 4 (R73, R85, R6) sampled residents reviewed for pressure injuries. * R73 was assessed to be at high risk for developing a pressure injury. A weekly skin check was not completed on 3/21/26. On 3/26/26 it was determined R73 developed a facility acquired stage 2 pressure injury to the back of the left thigh. Although the facility obtained a treatment order for the wound, there was no evidence that the treatment was performed daily, per order, from 3/26/26-3/30/26. When the facility re-assessed R73's pressure injury to the back of the left thigh on 3/30/26, the wound was now unstageable and noted to have 100% necrotic tissue. * R85 was admitted to the facility on [DATE] with an unstageable pressure injury to the right heel. R85's discharge orders from the hospital for daily wound care were not transcribed correctly into R85's Treatment Administration Record. R85 did not have a treatment completed to the right heel until after R85 was assessed by the wound physician on 3/23/2026. * R6 was readmitted to the facility on [DATE] with an unstageable coccyx pressure which R6 had developed prior to hospitalization. R6's coccyx treatment was not ordered until 4/10/26 and not implemented until 4/12/26. R6 has a pressure injury intervention dated 3/15/26 for an air mattress. R6's air mattress was not ordered until 4/12/26 and placed on R6's bed until 4/13/26, four days after readmission. R6 was observed with her heels not being offloaded. Findings include: The facility policy: Pressure Injury and Skin Impairment Prevention and Management with an Effective date of: 8/1/2025, and a revision Date of 3/10/26 states:IV. Procedural ComponentsA. Accountability1. The pressure Injury Prevention and Management Program identifies staff participation and accountability to include: a. Person responsible for program oversight and coordinationb. Staff involved in prevention and treatment (and their roles)c. Expectation of all caregivers to observe resident skin integrity during the daily provision of the resident's personal care. B. admission Skin Assessment and Management (includes)1. At the time of admission or readmission, discharge records from the prior facility are reviewed for information related to wounds or alterations in skin integrity. 2. Wounds are assessed at the time of admission (same shift) and if not possible, within 24-72 hours depending upon if weekend included.4. As risk areas are identified in the assessment tool, risk reduction measures are to be initiated.5. Orders for wound treatment are verified or obtained as needed. D. Process if a new in-house pressure injury is identified.1. A risk management report will be completed to include any information regarding the causing factors, resident statements, staff statements and interventions put in place. The risk management report will trigger a new Braden risk assessment to be completed and any changes identified will be reviewed and interventions will be implemented and care plans updated.2. The DON (Director of Nursing)/ designee will conduct a thorough investigation to determine the cause of each new in-house acquired pressure injury, in (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	addition to determining if avoidable. 3. If a wound that was present on admissions reopens to the same stage and not a higher stage, the pressure injury will be coded as a present-on-admission wound. If the wound reopens at a higher stage than was present on admission, then it will be considered to be in-house acquired. 1.) R73 was initially admitted to the facility on [DATE] with diagnoses including Cerebrovascular Disease, Diabetes Mellitus, Dysphagia, flaccid hemiplegia, chronic respiratory failure with hypoxia, bed confinement, tracheostomy. R73's care plan for resident has potential/actual impairment to skin integrity r/t (related to) Incontinence Date Initiated: 09/16/2025Revision on: 03/26/2026 includes the following interventions: * The resident will maintain or develop clean and intact skin by the review date. Date Initiated: 09/16/2025* Follow facility protocols for treatment of injury. Date Initiated: 09/16/2025* Provide good nutrition and hydration in order to promote healthier skin per MD/RD orders. Date Initiated: 09/16/2025. Revision on: 09/25/2025* Provide pressure relieving devices including Low Air loss mattress, cushion for chair, Offloading Boots. Date Initiated: 09/16/2025. Revision on: 10/05/2025* Turn and position as necessary. 9/16/25 The facility conducted the following Braden Assessments (tool for assessing a patient's risk of developing a pressure injury) :2/14/26- assessed at high risk2/24/26- assessed at very high risk3/9/26- assessed at very high risk3/23/26- assessed at high risk3/30/26- assessed at high risk. Review of R73's physician orders includes an order with a start date of 3/21/26 to complete a weekly skin assessment. Surveyor conducted a review of the most recent quarterly MDS (Minimum Data Set), dated 3/26/26. According to the MDS, R73 is severely cognitively impaired and non-verbal. R73 is always incontinent of urine and bowel. R73 has impairments in her range of motion to both sides, both upper and lower extremities. R73 is dependent on staff for all activities of daily living. R73 is at risk of developing a pressure injury and currently has an unhealed pressure injury, Stage 2. R73 is documented to have a pressure reducing device for the bed and chair and is receiving pressure injury care. Surveyor conducted further review of R73's electronic medical record and noted the following: Skin note dated 3/26/2026 at 11:36 AM: Skin Issue: #001: New skin Issue. Location: Rear left thigh. Issue type: Pressure injury / injury. Progress: New: new wound. Pressure injury staging: Stage 2 Pressure injury / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Exact date: 03/26/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 1.5 Width (cm): 3 Depth (cm): 0.1 Undermining: No. Tunneling: No. Granulation: 100%. Exudate amount: Moderate. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Other wound bed: none. Periwound: Rolled edge (Epibole). Surrounding tissue: Intact. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. Cleansing solution: Normal saline. Other primary dressing: Xeroform Gauze Other secondary dressing applied: Gauze Island Dressing Modalities: None. frequency of treatment: 1x / daily and as needed. Completed Clinical Suggestions: (none documented) Skin/ Wound noted dated 3/26/2026 at 11:39 AM; Reported to Writer, new skin issue noted by CNA (Certified Nursing Assistant), on inspection noted stage 2 to underside Left Buttock, measures 1.5 x (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3.0 x 0.1, wound bed beefy red, peri wound tissue fragile, no drainage at this time, Wound MD, Nurse Consultant, POA (power of attorney), NP (Nurse Practitioner) updated, Treatment initiated of Cleanse with S/W (saline water), pat dry, apply Xeroform gauze and cover w (with)/Border foam as secondary dressing, Change Daily & PRN (as needed). Skin/ wound note dated 3/26/2026 at 11:54 AM: Clarification to wound location, actually located on Posterior Left leg, distal to left buttock. Skin/ wound note dated 3/26/2026 at 12:11 PM: Reported to Writer, new skin issue noted by CNA, on inspection noted stage 2 to underside Left Buttock, measures 1.5 x 3.0 x 0.1, wound bed beefy red, peri wound tissue fragile, no drainage at this time, (name of Wound MD-F), Nurse Consultant, POA, (Name of medical group) NP (Nurse Practitioner) updated, Treatment initiated of Cleanse with S/W, pat dry, apply Xeroform gauze and cover w/Border foam as secondary dressing, Change Daily & PRN. Surveyor verified a Physician order was obtained on 3/26/26 for Wound Care: LT (left) POSTERIOR LEG - Cleanse with normal saline, pat dry, apply XEROFORM GAUZE, cover with ISLAND BORDER DRESSING every, day shift AND as needed for wound care. On 3/27/26 an additional order was obtained for nursing acknowledgment of skin assessment completed. If new skin issue, notify Physician for orders, notify family and complete the NAdvance Skin check. Every, day shift for wound management. Surveyor conducted a review of the Treatment Administration Records (TARs) for March 2026. It was noted that the weekly skin assessment was not signed out as completed on 3/21/26 and 3/28/26. The daily skin assessment was not signed out as being completed on 3/27/26, 3/28/26, 3/30/26 and 3/31/26. The daily treatment for the pressure injury to the left posterior leg was also not documented as being completed on 3/26/26, 3/27/26, 3/28/26, 3/29/26, and 3/30/26. A review of R73's care plan documents R73 has a pressure injury to her Lt (left) Posterior Leg and has the potential for pressure injury development, is at risk for delayed wound healing, and is at risk for further alteration in skin integrity due to Anticoagulant therapy, Braden Scale Score, Cerebral Vascular Accident, Contractures, Diabetes, Head of bed evaluated due to medical necessity, Immobility, Infection- current or recent, Limited joint mobility. Date Initiated: 03/26/2026. Revision on: 04/10/2026.Interventions include: * Pressure injury will show signs of healing and remain free from infection by/through review date. Date Initiated: 03/26/2026. * Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 03/26/2026* Administer treatments as ordered and monitor for effectiveness. Date Initiated: 03/26/2026* Assess/record/monitor wound healing Daily, Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Date Initiated: 03/26/2026. Revision on: 03/26/2026* Float heels with pillows when in bed. Date Initiated: 04/07/2026* Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 03/26/2026* Inform the resident/family/caregivers of any new area of skin breakdown. Date Initiated: 03/26/2026* Monitor dressing QS (each shift) to ensure it is intact and adhering. Report loose dressing to Treatment nurse. Date Initiated: 03/26/2026. Revision on: 03/26/2026* Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: 04/07/2026* Monitor/document/report PRN any (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length X width X depth), stage. Date Initiated: 03/26/2026* Offload bony areas with pillows/offloading devices. Date Initiated: 04/10/2026* The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested.Date Initiated: 04/07/2026. Revision on: 04/07/2026* The resident requires LAL (low air loss) mattress on bed- settings per manufacture guidelines. Check placement and function. Date Initiated: 03/26/2026. Revision on: 04/06/2026 Surveyor noted there are interventions including the use of a low air loss mattress that was on R73's plan of care going back to 9/16/25 with revisions on 10/5/25. Skin Note dated 3/30/2026 at 12:40 PM; N Adv (nursing advanced) -Skin Issues: Skin Issue: #001: Skin issue has been evaluated. Location: Rear left thigh. Issue type: Pressure injury / injury. Progress: New: new wound. Pressure injury staging: Unstageable pressure injury / injury. Unstageable injury due to slough and/or eschar. Wound acquired in-house. Exact date: 03/26/2026 Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 2 Width (cm): 3 Depth (cm): 0.1 Area (cm2): 6 Undermining: No. Tunneling: No. Eschar: 100%. Exudate amount: Moderate. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Other wound bed: none. Periwound: Attached. Surrounding tissue: Intact. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. Cleansing solution: Normal saline. Other primary dressing: Xeroform Gauze Other secondary dressing applied: Gauze Island Dressing Modalities: None. frequency of treatment: 1x / daily and as needed. Completed Clinical Suggestions: Wound Physician-F progress note dated 3/30/26 documents R73 has an unstageable (due to necrosis) pressure injury to the left posterior thigh. Healing potential is fair. Wound size is 2 cm x 3 cm x 0.1 cm. Surface area measures 6 centimeters. There is 100% thick adherent devitalized necrotic tissue. No pain and no signs of infection. The treatment order is to apply Xeroform gauze once daily and as needed if saturated, soiled or dislodged. Also apply a gauze island with border once daily and as needed. On 3/31/26, Director of Nursing (DON)- B documented on the Mitigating Factors for the development/ Worsening of Pressure Injuries form: (R73) has an in-house acquired pressure injury to the left thigh (rear). The form does not include documentation of any measurements or staging of R73's pressure injury. The date of onset is 3/26/26. Diagnosis contributing to risk is documented as continuous urinary incontinence, Diabetes, chronic bowel incontinence, Hypertension, Chronic diarrhea and history of pressure injuries. Treatment contributing to risk: head of bed elevated most of day due to medical necessity. The following new interventions put into place: keep (R73) dry and clean, linens free of wrinkles, moisture barrier after each incontinence episode, head of bed no higher than 30 degrees unless indicated, low air loss mattress, off load heels, IV (intravenous) fluids, wound MD/ specialist consult, Dietician consult, surgical or mechanical debridement of wound, on-going assessment of wound to evaluate signs of deterioration and/ or improvement of wound or possible change of treatment. Based on findings above, this wound is determined to be unavoidable? - facility checked yes. It was noted that the facility nursing staff did not obtain information regarding factors that led to F73 developing a facility acquired, unstageable pressure injury. Surveyor noted there was not a thorough investigation, per facility policy, to determine the root cause of R73's. R73 is completely dependent on staff for all activities of daily living due to quadriplegia. R73 is non-verbal so they would not be able to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	provide possible causative factors. The facility would need to rely on facility staff to determine possible factors that caused the pressure injury to the rear left thigh for R73. Surveyor noted prior to R73 developing a stage 2 pressure injury that deteriorated to unstageable R73's care plan for at risk for pressure injuries was not revised as R73's risks changed to be individualized for R73's risk factors. On 4/2/2026 at 5:00 PM, R73 was assessed by APNP (advanced practice nurse practitioner)-D for SNF (skilled nursing facility) progress follow-up and wound care. The following was noted in the progress note; (R73) is seen for a skilled nursing facility progress visit. (R73) is up in a Broda chair and appears comfortable. She is adjusting to a recent room change. Vitals have been reviewed in the electronic medical record. She is on 35% oxygen via T-piece with oxygen saturations at 95%. Wound notes from March 30, 2026 have been reviewed. She has an unstageable right (sic) posterior thigh wound measuring 2 x 3 x 0.1 cm with treatment in place. She also has a skin tear wound on the right knee measuring 1 x 1 cm with treatment in place. The patient remains afebrile. SKIN- Unstageable right (sic) posterior thigh wound 2 x 3 x 0.1 cm, treatment in place, Skin tear wound right knee 1 x 1 cm, treatment in place. Assessment and Plan: Pressure injury of unspecified site, stage 3. * Skin tear wound on right knee measuring 1 x 1 cm documented on 3/30/2026 with treatment in place. Wound noted on today's exam with treatment in place. Continue current wound care regimen. Monitor for signs of infection and healing progression. Follow-up: Continue wound care for right (sic) posterior thigh and right knee wounds per wound care orders; reassess at next visit Skin Note dated 4/6/2026 at 09:30 AM; N Adv - Skin Issues: Skin Issue: #001: Skin issue has not been evaluated. Location: Rear left thigh. Issue type: Pressure injury / injury. Pressure injury staging: Unstageable pressure injury / injury. Wound acquired in-house. Exact date: 03/26/2026 Staged by: Health care provider. Undermining: No. Tunneling: No. Skin Issue: #002: Skin issue is resolved. Location: Front right knee. Issue type: Skin tear. Progress: Resolved: Wound healed and / or closed. Type 3: Total flap loss. Wound acquired in-house. It is unknown how long the wound has been present. Staged by: N/A. Undermining: No. Tunneling: No. Completed Clinical Suggestion (none noted). Skin Note dated 4/6/2026 at 09:31 AM; N Adv - Skin Issues: 0Skin Issue: #001: Skin issue has been evaluated. Location: Rear left thigh. Issue type: Pressure injury / injury. Progress: Improving: overall wound characteristics improved. Pressure injury staging: Unstageable pressure injury / injury. Unstageable injury due to slough and / or eschar. Wound acquired in-house. Exact date: 03/26/2026 Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 1 Width (cm): 1.5 Depth (cm): 0.1 Area (cm2): 1.5 Undermining: No. Tunneling: No. Granulation: 80%. Eschar: 20%. Exudate amount: Moderate. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Other wound bed: none. Periwound: Attached. Surrounding tissue: Denuded. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. Cleansing solution: Normal saline. Other primary dressing: Xeroform Gauze Other secondary dressing applied: Gauze Island Dressing Modalities: None. frequency of treatment: 1x / daily and as needed. 4/13/2026 07:32 N Adv - Skin Issues: Skin Issue: #001: Skin issue has been evaluated. Location: Rear left thigh. Issue type: Pressure injury / injury. Progress: Improving: overall wound characteristics improved. Pressure injury staging: Stage 3 Pressure injury / injury - full thickness skin loss. Wound acquired in-house. Exact date: 03/26/2026 Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 0.5 Width (cm): 1 Depth (cm): 0.2 Area (cm2): 0.5 Undermining: No. Tunneling: No. Granulation: 100%. Exudate amount: Moderate. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Other wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	bed: none. Periwound: Attached. Surrounding tissue: Intact. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. Cleansing solution: Normal saline. Debridement: Autolytic. Other primary dressing: Xeroform Gauze Other secondary dressing applied: Gauze Island Dressing Modalities: None. frequency of treatment: 1x / daily and as needed. On 4/14/26 at 9:54 AM, Surveyor observed R73 in bed on the specialty air mattress. The facility staff performed the daily treatment to R73's pressure injury on the back of the left thigh. Surveyor noted the area to be 100% granulation, healing and pink scar tissue with small open area. R73 had heels floating on pillows and pillows placed on each side for positioning. On 4/14/26 at 11:36 AM, Surveyor interviewed DON- B regarding R73 developing a facility acquired pressure injury to the back of the left thigh. DON-B stated that she did get a physician order for a treatment to the pressure injury on 3/26/26. DON- B stated that R73 was already on a specialty low air loss mattress prior to developing the pressure injury. Surveyor asked DON- B why the skin assessments on 3/30/26, completed by Wound Physician-F documented that R73 had a new pressure injury, less than 1 day old to the left rear thigh. DON- B stated that she always puts new area until it is assessed by Wound Physician-F in case he wants to change the staging of the wound. DON- B verified that Wound MD-F did not assess the wound until 3/30/26 even though the wound was first observed on 3/26/26. Surveyor shared with DON- B the concerns regarding the March 2026 Treatment Administration Record not having documentation that the treatment was completed on 3/26/26, 3/27/26, 3/28/26. DON-B verified that yes, the treatment was not signed out as being completed on those days. Surveyor also mentioned that the weekly skin assessment was not signed out as completed on 3/21/26 and 3/28/26 and the daily skin assessment was not signed out as being completed on 3/27/26, 3/28/26, 3/30/26 and 3/31/26. DON- B also verified those dates were not signed out as being completed on the Treatment Administration Record. DON- B stated that she could not be sure if the skin assessments and treatments were completed or not and this would have been the responsibility of the Nurse Manager to make sure it was completed. DON- B stated that yes, the expectation is that staff are to sign/ initial completion on the Treatment Administration Record. DON- B stated that on 3/30/26, Wound Physician-F and a Nurse Consultant assessed the wound. DON- B confirmed that on 3/26/26, her assessment of the pressure injury was a stage 2 and on 3/30/26, the wound was now assessed as being unstageable due to being 100% necrotic. DON- B stated that currently the facility does not have a wound nurse in-house daily. The floor nurses are to make sure treatments are being done. DON- B stated that she is only responsible for entering the data into the medical record regarding the pressure injury. Surveyor asked DON- B if there were any new individualized interventions put into place after R73 developed the pressure injury to the left rear thigh. DON-B stated (R73) already had all of the things in place like the air mattress and turning and repositioning. DON- B was not able to provide any additional information on how the pressure injury may have developed to prevent further pressure injury development for R73. On 4/14/26 at 2:00 PM, Surveyor informed Administrator- A and DON- B the concerns about R73 and the development of the pressure injury to the rear left thigh. Surveyor discussed concerns that there is no evidenced the facility staff were checking the skin daily, per order starting 3/27/26. Additionally, there was no evidence that the treatment was completed on 3/26-3/29/26. When the area was first observed it was assessed to be a Stage 2. On 3/30/26, the area grew, in size, and was now 100 % necrotic. Surveyor discussed that the facility did not complete a root cause analysis to determine how the pressure injury may have developed and then updated the care plan with individualized interventions for further prevention. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2.) R85 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, anemia, Parkinsonism, and pulmonary hypertension. R85's admission Minimum Data Set (MDS) assessment dated [DATE] documented R85 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and an Unstageable pressure injury that was present upon admission. R85's hospital discharge paperwork documented an order for Mepilex border dressing daily over the wound area on the right leg. On 3/18/2026 on the admission Data Collection and Baseline Care Plan Tool, nursing documented R85 had a wound to the right heel. On the Clinical admission form, nursing documented R85 had an Unstageable pressure injury to the right heel measuring 4.0 cm x 4.0 cm x 0.1 cm with slough. No treatment to the right heel was found on the Treatment Administration Record (TAR). The physician orders documented to apply Mepilex border dressing to the right heel daily until healed. The order was entered into R85's medical record on 3/18/2026. The nurse that entered the order did not select a time for the treatment to be completed and therefore did not get entered into the TAR to be completed daily. On 3/21/2026 at 8:20 PM in the progress notes, nursing documented R85 requested to go to the hospital for pulmonary reasons. R85 was transported to the hospital. On 3/21/2026 in the emergency room documentation, R85 expressed discontent regarding wound care which R85 stated had not been done to the right heel wound. R85 was assessed and treated at the hospital and sent back to the facility that night with orders for the right heel pressure injury: remove old dressing, wash with gentle soap and water, rinse, pat dry, apply Iodosorb, cover with Allevyn, and change the dressing three times per week and as needed. This order was not transcribed into R85's TAR at the facility. On 3/23/2026, R85 was seen by wound physician-F on wound rounds. The wound physician assessed the right heel pressure injury and ordered a treatment to the wound. This order was transcribed on 3/24/2026 and the treatment was first signed out on 3/25/2026 as being completed. R85 discharged from the facility on 4/6/2026 and was not in the facility at the time of the survey. In an interview on 4/13/2026 at 1:34 PM, Surveyor asked Assistant Director of Nursing (ADON)-C what the facility process was for putting in hospital discharge/facility admission medication and treatment orders. ADON-C stated the nurse on the floor that is admitting the resident enters the hospital discharge orders from the Discharge Summary into the resident's medical record. ADON-C stated the nurse contacts the physician to verify the orders and a second check of the orders is done by the Unit Manager usually the next day. Surveyor asked ADON-C if a resident is admitted with a pressure injury, how are treatment orders obtained. ADON-C stated treatment orders normally come on the Discharge Summary, but if there are no treatment orders on discharge, the wound nurse or Registered Nurse will consult with the wound physician and verify what orders they would like in place. ADON-C stated the wound physician (F) comes weekly on Mondays and will look at all residents with pressure injuries. ADON-C stated the wound physician (F) will make an initial assessment of a new resident at that time and make the decision if the treatment is appropriate or if a different treatment would be better at that time. ADON-C stated there is an outside consultant that follows up with orders and interventions to make sure everything is in place for residents with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Amethyst Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	pressure injuries. Surveyor shared with ADON-C concerns R85 was admitted on [DATE] with an Unstageable pressure injury to the right heel and the treatment order from the Discharge Summary was not on R85's TAR, a new wound treatment was ordered on 3/21/2026 after an emergency room visit that was not transcribed, and R85 went five days with no treatment to the right heel pressure injury. On 4/14/2026 at 11:55 AM, Surveyor shared with Director of Nursing (DON)-B the concerns R85 did not have a treatment order in place at the time of admission on [DATE] for the Unstageable pressure injury to the right heel, a treatment order obtained on 3/21/2026 was not transcribed, and the first treatment to the right heel pressure injury was 3/25/2026 after R85 was seen by the wound physician on 3/23/2026, two days later. At 1:56 PM, Surveyor shared the same concerns with Nursing Home Administrator (NHA)-A. 3.) R6's diagnoses include chronic respiratory failure (long term condition where the lungs cannot adequately exchange oxygen and carbon dioxide), dysphagia (difficulty swallowing), encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), malignant neoplasm (cancer) of colon, and diabetes mellitus (high blood sugar) . R6's admission MDS (minimum data set) with an assessment reference date of 12/25/25 assesses R6's short term & long-term memory as ok. Cognitive skills for daily decision making is modified independence. Speech clarity is assessed as no speech. R6 is assessed as not having any behavior including refusal of care. 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 urine & bowel. R6 is at risk for pressure injuries and is assessed as not having any pressure injuries. R6's pressure injury CAA (care area assessment) dated 12/29/25 under analysis of findings for nature of problem/condition documents the resident has potential impairment to skin integrity. Under care plan considerations for describe impact of this problem/need on the resident and your rationale for care plan decisions it is documented Encourage good nutrition and hydration in order to promote healthier skin. R6's pressure injury care plan initiated 3/3/26 and revised 3/15/26 documents the following interventions: *Administer treatments as ordered and monitor for effectiveness. Initiated 3/3/26. *Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Initiated 3/3/26. *Follow facility policies/protocols for the prevention/treatment of skin breakdown. Initiated 3/3/26. *Inform the resident/family/caregivers of any new area of skin breakdown. Initiated 3/3/26. *Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x (times) width x depth), stage. Initiated 3/3/26. *Teach resident/family the importance of changing positions for prevention of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Encourage small frequent position changes. Initiated 3/3/26 *The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. Initiated & revised 3/3/26. *The resident requires pressure reducing devices on bed/chair. Initiated & revised 3/3/26. *[Wound company name] wound MD (medical doctor) rounds. Initiated 3/3/26. *Weekly treatment documentation to include measurement of each area of skin breakdown's (sic) width, length, depth, type of tissue and exudate. Initiated 3/3/26. *Air mattress in place with appropriate settings and functioning properly. Initiated 3/15/26. *Encourage adequate nutrition to promote wound healing. Initiated 3/15/26. *Moisture barrier cream/ointment after each incontinent episode. Initiated 3/15/26. *Offload bony areas using pillows, foam wedges, and/or offloading devices. Initiated 3/15/26. *Pressure redistributing cushion to wheelchair. Initiated 3/15/26. *Provide incontinence care as needed. Initiated 3/15/26. *Reposition at least hourly while in wheelchair and as needed and Q (every) 2 hours while in bed. Initiated 3/15/26. Surveyor reviewed R6's wound MD-F assessment and noted a wound assessment dated [DATE] which documents an unstageable coccyx pressure injury. Measurements 1 x (times) 0.8 x 0.3 cm (centimeters) with 100% necrotic tissue and Stage 3 right buttocks pressure injury with measurements of 0.3 x 0.3 x 0.1 cm and wound bed 100% granulation. R6 was transferred to the hospital on 3/26/26 and returned to the facility on 4/9/26.R6's nurses note dated 4/9/26 at 16:22 (4:22 p.m.) written by Registered Nurse (RN)-E documents readmitted to room [number] per stretcher, via [Name] ambulance services, accompanied by 2 EMTs (emerg

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Uncorrected on revisitBased on interview and record review, the facility did not ensure 1 (R10) of 2 sampled residents with orders to reweigh related to fluxuations in weights.*R10's nurse practitioner (NP) requested R10 be reweighed on 4/9/26, and the facility did not follow up on this request. Findings include: R10 admitted to the facility on [DATE] with diagnoses including mild protein-calorie malnutrition. R10's quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately impaired cognition. Surveyor reviewed R10's electronic health record (EHR) and located the following weights:3/23/26 157.0 pounds4/5/26 157.0 pounds4/6/26 151.3 pounds A progress note dated 4/9/26 written by NP-D documents weight on 4/6/26 was 151.3 pounds, reweight is needed for accuracy . follow up: reweight for accuracy given significant weight decrease. Surveyor was unable to locate an updated weight in R10's EHR after R10's NP requested R10 be reweighed for accuracy, and the most recent weight listed in R10's EHR was from 4/6/26. In an interview on 4/14/26 at 11:55 AM, Director of Nursing (DON)-B stated if the NP makes any recommendations after seeing a resident, these recommendations are given verbally or in writing to the unit nurse manager on the floor. DON-B stated if the NP requested a resident be reweighed, this should be completed within 24 hours of the NP's request. Surveyor shared concern with DON-B that R10's NP requested R10 be reweighed on 4/9/26 and Surveyor was unable to locate evidence R10 was reweighed. No additional information was provided. In an interview on 4/14/26 at 1:00 PM, NP-D stated if NP-D has a recommendation or new order after seeing a resident, NP-D notifies DON-B or one of the nurses at the facility. NP-D stated if NP-D recommends a resident is reweighed for accuracy, NP-D would expect the facility to reweigh a resident within one day of that recommendation. On 4/14/26 at 1:56 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R10's NP (D) requested R10 be reweighed on 4/9/26 and Surveyor was unable to locate any evidence the facility completed this request.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents requiring respiratory care was provided with oxygen for 1 (R85) of 4 residents reviewed on oxygen. R85 had orders on admission for oxygen therapy 2 liters/minute at night. This order was not transcribed. R85 received oxygen without an active order for oxygen. The oxygen order that was obtained three days after admission did not specify the amount of oxygen to administer and R85 was not being monitored on an ongoing basis to determine the needs of oxygen. Findings include: The facility policy and procedure titled Oxygen Administration dated 8/1/2025 documents: Preparation: 1. Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed.Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. (as needed) administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why, and the intervention taken. 9. The signature and title of the person recording the data. The facility policy and procedure titled Physician Orders dated 8/1/2025 documents: Recording Orders . 3. Oxygen Orders - When recording orders for oxygen, specify the rate of flow, route and rationale. Example: Oxygen 3L/min per nasal cannula as needed for shortness of breath. R85 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease, and pulmonary hypertension. R85's admission Minimum Data Set (MDS) assessment dated [DATE] documented R85 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and on oxygen. R85's hospital discharge paperwork documented an order for oxygen at 2 liters/minute nightly. On 3/18/2026 on the admission Data Collection and Baseline Care Plan Tool, nursing documented R85's oxygenation was 90% on room air and R85 uses oxygen. On the Clinical admission form, nursing documented R85 did not use supplemental oxygen. No order for oxygen was found in R85's medical record for the use of oxygen as ordered on the hospital discharge summary on 3/18/2026. Surveyor noted the admission Data Collection and Baseline Care Plan Tool conflicted in the use of oxygen. The admission Data Collection and Baseline Care Plan Tool initiated R85's Oxygen Care Plan. No interventions documenting the rate of oxygen or the frequency of oxygen was included in the Care Plan. On 3/19/2026 at 5:56 AM in the progress notes, nursing documented R85's oxygenation was 98% on 2 liters of oxygen per nasal cannula. At 10:00 AM in the progress notes, a Nurse Practitioner (NP) documented R85 was currently on 3 liters of oxygen which was increased from the home baseline of 2 liters of oxygen at night. The NP documented R85 had recently been requiring oxygen during the day as well and the current oxygenation was 90%. Surveyor noted R85 did not have an active order for oxygen use. On 3/21/2026, an order was entered into R85's medical record: titrate oxygen to keep SpO2 (oxygen level) greater than 90%. Surveyor noted the order did not indicate the rate of oxygen or the duration, continuous or at night only. R85 discharged from the facility on 4/6/2026 and was not in the facility at the time of the survey. In an interview on 4/13/2026 at 1:34 PM, Surveyor asked Assistant Director of Nursing (ADON)-C what the facility process was for putting in hospital discharge orders. ADON-C stated the nurse on the floor that is admitting the resident enters the hospital discharge orders from the Discharge Summary into the resident's medical record. ADON-C stated the nurse contacts the physician to verify the orders and a second check of the orders is done by the Unit Manager usually the next day. Surveyor shared with ADON-C the concern R85 was admitted on [DATE] with an order for oxygen at night that was not transcribed on admission and received oxygen without having an active order for the use of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/2026 at 11:55 AM, Surveyor shared with DON-B the concerns R85 was admitted with orders for oxygen use which was not transcribed into R85's medical record. Documentation was found on 3/18/2026 and 3/19/2026 indicating R85 was using oxygen when R85 did not have an active order for oxygen use. Surveyor shared the concern the oxygen order that was obtained on 3/21/2026 did not specify the rate or duration of the oxygen nor was there monitoring of R85's oxygenation level to determine if R85 was staying above the ordered 90% oxygenation. At 1:56 PM, Surveyor shared the same concerns with Nursing Home Administrator (NHA)-A.