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	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 4 (R9, R90, R81, and R28) out of 9 sampled residents were provided and administered medications based upon physician orders and standards of practice for ensuring accurate administration of ordered medications. *R9 did not receive Olanzapine 2.5 mg (milligrams) and Atorvastatin Calcium 40 mg at bedtime and Memantine 5 mg at 2000 (10:00 PM) on 4/7/26 and 4/28/26. R9's medication administration record (MAR) did not accurately detail why R9's medications were not administered on 4/5-4/6/26 when R9 was hospitalized . *R90 had multiple administrations of medications not documented as given during March and May of 2026. *R81 had multiple administrations of medications not documented as given during April and May of 2026. *R28 did not receive Gabapentin 400 mg (milligrams) and Baclofen 20 mg at 2000 (8:00 p.m.) and did not receive Tylenol 650 mg at 1800 (6:00 PM) on 4/8/26 and 4/27/26. Findings include: The facility's policy titled, Documentation of Medication Administration, April 2007, documents, Policy heading: The facility shall maintain a medication administration record to document all medications administered. Policy Interpretation and Implementation: 1. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given. 3. Documentation must include, as a minimum: a. name and strength of the drug; b. dosage; c. method of administration (e.g., oral, injection (and site), etc.); d. date and time of administration; e. reason(s) why a medication was withheld, not administered, or refused (as applicable); f. signature and title of the person administering the medication; and g. resident response to the medication, if applicable (e.g., PRN, pain medication, etc.) 1.) R9 was readmitted to the facility on [DATE] with an initial admission date of 8/30/24. R9 has a diagnoses that include Cognitive Communication Deficit, Hypertensive Heart Disease, Congestive Heart Failure, Pulmonary Arterial Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction (stroke), Dementia and other behavioral disturbances, and Depression. R9's quarterly Minimum Data Set (MDS) assessment, dated 3/17/26, documents R9 has a Brief (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview for Mental status (BIMS) of 5, indicating severe cognitive impairment. R9's Medication Administration Record (MAR) for April 2026, documents the following medications are to be administered, in part . Atorvastatin Calcium oral tablet 40 mg (milligrams) – Give 1 tablet by mouth at bedtime for lower cholesterol in blood. Start date: 3/10/26, Olanzapine oral tablet 2.5 mg – by mouth at bedtime for gradual dose reduction. Start date 3/18/26 and, Memantine HCl oral tablet 5 mg – Give 1 tablet by mouth two times a day for dementia at 0800 (8:00 AM) and 2000 (10:00 PM). Start date: 3/10/26. R9's MAR does not document R9 received medication administration from 4/5/26 to 4/9/26 nor does it include details to indicate why it may have not been administered. Surveyor reviewed progress notes and determined R9 was hospitalized during this time. The MAR does not reflect the medications were held due to hospitalization. R9's MAR does not document R9 received Olanzapine 2.5 mg (milligrams) and Atorvastatin Calcium 40 mg at bedtime and Memantine 5 mg at 2000 (10:00 PM) on 4/7/26 and 4/28/26. Surveyor reviewed R9's Progress Notes and did not find any evidence as to why R9's medications were not received on 4/7/26 and 4/28/26.R9's Care Plan Focus Area, revision dated 8/19/25, documents, Resident utilizes antianxiety/antidepressant/antipsychotic medications r/t dx of UNSPECIFIEDDEMENTIA, UNSPECIFIED SEVERITY, WITH PSYCHOTIC DISTURBANCE (sic). Interventions include, in part. Administer PSYCHOTROPIC medications as ordered by physician, revision dated 03/13/25. R9's Care Plan Focus Area, revision dated 3/20/25, documents, The resident has impaired cognitive function/dementia or impaired thought processes r/t Difficulty making decisions, Impaired decision making. Interventions include, in part. Administer medications as ordered. Monitor/document for side effects and effectiveness revision dated, 03/13/25. On 5/20/26 at 9:24 AM, Surveyor interviewed Licensed Practical Nurse (LPN) -D. Surveyor asked LPN-D how does LPN-D document when a medication is administered to a resident. LPN-D stated LPN-D documents in the MAR after LPN-D has given the medication. On 5/20/26 at 10:13 AM, Surveyor interviewed LPN-C asking about different factors that could be a possible reason for a resident to not be administered medications. Surveyor asked LPN-C what LPN-C does when there is not a medication available for a resident. LPN-C stated If the medication is a stock medication, LPN-C will obtain it from the central supply, if the medication is a prescription, LPN- C will obtain it from the facility's contingency supply and then call the pharmacy to reorder the medication for the resident. Surveyor asked LPN-C, what does LPN-C do if a resident refuses medication. LPN-C stated, LPN-C will indicate the refusal in the Medication Administration Record (MAR), place resident on the 24-hour board, notify the physician, management, and Power of Attorney (POA) if applicable, and then document in a progress note. On 5/20/26 at 9:33 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked DON-B if anyone verifies the nurses have documented medication administration. DON-B stated DON-B and management complete random spot checks to audit medication administration has been provided and documented. If a nurse has missed documenting, DON-B will call the nurse within 24 hours to find out if the medication was administered and if yes, assure the nurse documents. If not, find out the reason why and follow up accordingly. Surveyor notified DON-B that R9 did not receive the listed above (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications on 4/7/26 and 4/28/26. Surveyor asked who the staff member was that was working the East unit, evening shift, on these dates. On 5/20/26 at 10:52 AM, DON-B provided the evening schedule for the East unit for 4/7/26 and 4/28/26. DON-B stated LPN-H was responsible for administering medication to R9 on these dates. Surveyor asked DON-B if there was a concern or pattern with LPN-H not documenting medication administration and DON-B stated, yes, LPN-H was someone who would frequently forget to chart and had to be told to complete documentation. 2.) On 5/19/26, at 10:27 AM, Surveyor Interviewed R90. R90 stated they feel like they don't always get all of their medications as prescribed on 2nd and 3rd shifts. R90 denied knowing the names of specific staff that do not give R90 all of the medications ordered. R90 denied knowing what specific medications are missing. On 5/19/26, at 11:30 AM, Surveyor reviewed R90's Medication Administration Record (MAR) from February 2026 to May 2026. Medications were noted to be blank for multiple dates. Surveyor noted the following medications and dates not administered to R90 in March 2026; Fluoxetine 40 mg capsule 1 time a day not given from 3/6/26 – 3/8/26; Quetiapine 50 mg 1 time a day not given 3/6/26 – 3/8/26, 3/20/26, 3/3026, and 3/31/26; Vraylar 1.5 mg 1 time a day not given from 3/6/26 – 3/8/26, 3/20/26, 3/21/26, and 3/30/26; buspirone 5 mg 1 tablet 2 times a day not given on 3/6/36 bedtime, 3/7/26 morning, 3/8/26 morning, 3/13/26 morning, and 3/20/26 morning; hydralazine 10 mg 1 tablet 2 times a day 3/6/26 morning and bedtime, 3/7/26 morning and bedtime, and '3/8/26 morning. On 3/9/26, the following medications were not administered in the morning to R90: Duloxetine HCL delayed release 60 mg 1 capsule by mouth 1 time a day, Fluoxetine 40 mg capsule 1 time a day, Pantoprazole delayed released 40 mg 1 time a day, Vraylar 1.5 mg 1 time a day, buspirone 10 mg 1 tablet 2 times a day, Fluticasone Salmeterol 100-50 1 puff 2 times a day, gabapentin 300 mg 2 capsules 2 times a day, hydralazine 10 mg 1 tablet 2 times a day, lisinopril 10 mg 1 time a day, and metoprolol tartrate 100 mg 1 tablet 2 times a day. On 5/7/26 at (HS) bedtime the following medications were not administered to R90 Seroquel 25 mg tablet 1 tablet at bedtime, Trazodone HCL 50 mg tablet give 2 tablets by mouth, Baclofen 10 mg tablet give 1 tablet by mouth 2 times a day, Buspirone 5 mg tablet give 1 tablet by mouth 2 times a day, Fluticasone Salmeterol 100-50 1 puff 2 times a day, Gabapentin 300 mg 2 capsules 2 times a day, hydralazine 10 mg 1 tablet 2 times a day, Metoprolol Tartrate 100 mg tablet 1 tablet 2 times a day, Surveyor noted the following medications and dates not administered to R90 in May 2026; Duloxetine HCL delayed release 60 mg 1 capsule by mouth 1 time a day not given on 5/8/26, buspirone 5 mg 1 tablet 2 times a day not given on 5/8/26, Lidocaine external patch 5% topically every day shift was not given on 5/14/26, Surveyor reviewed R90's Electronic Medical Record and did not identify any progress notes addressing why R90 did not receive medications as ordered on the dates listed above. On 5/20/2026, at 9:53 AM, Surveyor Interviewed Director of Nursing (DON) – B and Regional Nurse (RE)-E regarding missing medication administrations for R90. DON-B expected Nursing staff to sign out the medication as it is given and if the medication cannot be given the Nurse needs to call the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's physician and document why the medication wasn't given and if there were new orders from the resident's physician. RE-E stated the facility will do spot checks to affirm medications are being dispensed as ordered. On 5/20/26, at 10:00 AM, Surveyor shared the concern of R90 not receiving ordered medications with Nursing Home Administrator (NHA)-A, DON-B, and RE-E. 3.) On 5/19/26 at, 12:00 PM, Surveyor reviewed R81's MAR from February 2026 to May 2026. Medications were noted to be blank on multiple dates. Surveyor noted the following medications and dates not administered to R81 in April 2026; Umeclidinium – Vilanterol inhalation aerosol powder breath activated 62.5 – 25 mcg/act 1 puff inhale orally one time a day for COPD not given on 4/10/26 and 4/13/26 and Zolpidem Tartrate 5 mg give 1 tab by mouth at bedtime not given at on 4/16/26 and 4/27/26. Surveyor noted the following medications and dates not administered to R81 in May 2026; Pramipexole 1 mg tablet give 1.5 mg by mouth at bedtime not given on 5/7/26, Zolpidem Tartrate 5 mg give 1 tab by mouth at bedtime not given on 5/7/26, and Metformin HCL tablet 500 mg 1 tablet by mouth 2 times a day was not given on 5/7/26 at bedtime. Surveyor reviewed R81's Electronic Medical Record and did not identify any progress notes addressing why R81 did not receive medications as ordered on the dates listed above. On 5/19/26, at 12:51 PM, Surveyor Interviewed R81. R81 denied knowing if any medications are missing when medications are dispensed to R81. Surveyor reviewed R81's Electronic Medical Record and did not identify any progress notes addressing why R81 did not receive medications as ordered on the dates listed above. On 5/20/2026, at 9:53 AM, Surveyor Interviewed Director of Nursing (DON) – B and Regional Nurse (RE)-E regarding missing medication administrations for R81. DON-B expected Nursing staff to sign out the medication as it is given and if the medication cannot be given the Nurse needs to call the resident' s physician and document why the medication wasn't given and if there were new orders from the resident's physician. RE-E stated the facility will do spot checks to affirm medications are being dispensed as ordered. On 5/20/26, at 10:00 AM, Surveyor shared the concern of R81 not receiving ordered medications with Nursing Home Administrator (NHA)-A, DON-B, and RE-E. 4.) R28's diagnoses include bipolar disorder (mental disorder characterized by periods of depression and periods of abnormally elevated mood), quadriplegia (partial or total paralysis of all four limbs and torso), other chronic pain, & other muscle spasms. R28's resident has a diagnosis of chronic pain r/t (related to) disease processes and neuropathy care plan initiated 6/2/22 & revised 5/20/23 includes an intervention of Administer analgesia as per orders. Give 1/2 hour before treatment or care initiated 6/2/22 & revised 2/15/23. R28's resident is on pain medication therapy r/t (related to) disease process care plan initiated & (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised 7/10/22 documents an intervention of Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness Q (every) shift. Initiated 7/10/22. R28's significant change MDS (minimum data set) with an assessment reference date of 3/20/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. On 5/19/26, at 9:59 a.m., during a conversation with R28, Surveyor asked R28 if anyone refused to give him his medication. R28 replied, not necessarily refused but slow and late. Surveyor asked if he ever didn't receive his medication. R28 informed Surveyor he doesn't recall not receiving his medication. Surveyor reviewed R28's physician orders and noted the physician orders include: *Gabapentin Oral Tablet 400 mg (milligrams) (Gabapentin) Give 1 tablet by mouth two times a day for pain with an order date of 3/26/26. *Baclofen Oral Tablet 20 mg (Baclofen) Give 1 tablet by mouth four times a day for spasms with an order date of 4/1/24. *Tylenol Tablet 325 mg (Acetaminophen) Give 2 tablet by mouth every 6 hours for pain with an order date of 4/1/24. Surveyor reviewed R28's April 2026 MAR (medication administration record) and noted on 4/8/26 R28 did not receive Gabapentin 400 mg at 2000 (8:00 p.m.) & Baclofen 20 mg at 2000 (8:00 p.m.) and Tylenol 650 mg at 1800 (6:00 p.m.). On 4/27/26 R28 did not receive Gabapentin 400 mg at 2000 (8:00 p.m.) & Baclofen 20 mg at 2000 (8:00 p.m.) and Tylenol 650 mg at 1800 (6:00 p.m.). On 5/20/26, at 12:08 p.m., Surveyor asked Director of Nursing (DON)-B what the expectation is when a medication is administered. DON-B replied they sign off once it's been administered. Surveyor informed DON-B of R28 not receiving his evening medication on 4/8/26 & 4/27/26.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility did not ensure a medication was administered with adequate monitoring for 1 (R91) of 1 sampled residents with parameters to hold medication based upon assessed blood pressures at time of medication administration.* The facility did not assure R91's blood pressures were assessed and documented prior to administering Midodrine HCL to R91 as ordered by the physician. Findings include;R91's diagnosis includes orthostatic hypotension (sudden, excessive drop in blood pressure that occurs when rising from a sitting or lying position). R91 was discharged from the facility on 4/19/26.R91's orders include Midodrine HCl Tablet 10mg (milligrams) Give 1 tablet by mouth three times a day for orthostatic hypotension hold SBP (systolic blood pressure) greater than 150 with an order date of 3/23/26.Surveyor reviewed R91's March 2026 & April 2026 MAR (medication administration record) and noted these MARs include Midodrine HCl 10 mg with administration times of 0800 (8:00 a.m.), 1200 (12:00 p.m.) & 1600 (4:00 p.m.). Surveyor noted there is only a box indicating whether the medication has been administered. There is not a box for R91's blood pressure value prior to administration of Midodrine 10 mg.Surveyor reviewed R91's blood pressure readings under the vital sign tab in R91's electronic medical record.Surveyor noted R91's blood pressure was not obtained prior to administering Midodrine 10 mg on the following dates & times:3/24/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 3/25/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 3/26/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 3/27/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 3/28/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 3/29/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 3/30/26 at 8:00 a.m. & 4:00 p.m., 3/31/26 at 8:00 a.m. & 12:00 p.m., 4/1/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 4/2/26 at 8:00 a.m. & 4:00 p.m., 4/3/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 4/4/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 4/8/26 at 8:00 a.m. & 4:00 p.m., 4/9/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 4/10/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 4/11/26 at 8:00 a.m. & 12:00 p.m. 4/12/26 at 8:00 a.m. & 4:00 p.m., 4/13/26 at 8:00 a.m. & 4:00 p.m., 4/14/26 at 8:00 a.m. & 4:00 p.m., 4/15/26 at 8:00 a.m. & 4:00 p.m., 4/16/26 at 12:00 p.m., & 4:00 p.m., 4/17/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., 4/18/26 at 8:00 a.m., 12:00 p.m., & 4:00 p.m., and 4/19/26 at 8:00 a.m.On 5/20/26, at 8:11 a.m., Surveyor asked Licensed Practical Nurse (LPN)-I if a physician order has vital signs to be obtained prior to administering a medication to determine if the medication should be held; where would the vital sign be documented. LPN-I informed Surveyor sometimes the MD (medical doctor) order pops up in the MAR to document.On 5/20/26, at 8:15 a.m., Surveyor asked LPN-J if a physician order has vital signs to be obtained prior to administering a medication to determine if the medication should be held where; would the vital sign be documented. LPN-J informed Surveyor in the MAR.On 5/20/26, at 11:59 a.m., Surveyor asked Director of Nursing (DON)-B if a MD order has parameters to hold medication where the vital signs such as blood pressure are documented. DON-B informed Surveyor it would depend on how the order is written to include the vital sign. Surveyor informed DON-B R91 has an order for Midodrine 10 mg three times a day with instructions to hold the medication if systolic blood pressure is greater than 150. Surveyor informed DON-B there is not a box for the nurse to enter R91's blood pressure prior to administration and R91's blood pressure was not consistently obtained prior to administering the medication. DON-B informed Surveyor they pretty much put the order in without parameters.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 3 (R81,R90, and R73) of 3 sampled residents were free from significant medication errors. * R81 had a missing dose of Apixaban (Eliquis) 5 mg on 5/7/26 at 8:00 PM. * R90 had 2 missing doses of Apixaban (Eliquis) 5 mg on 5/7/26 at 8:00 PM and on 3/9/26 at 8:00 AM. *R73 admitted to the facility on [DATE] with an order for Truvada Oral Tablet 200-300mg. Give 1 tablet via G-Tube one time a day . Multiple doses were marked as not administered between 2/25/26 and 3/9/2026 due to waiting for pharmacy. Findings Include: The facility's policy titled Administering Oral Medications dated 8/1/2025 and last revised on 3/1/2026 documented: . Verify that there is a physician's medication order for this procedure. Review the resident's care plan to assess for any special needs of the resident. Notify the supervisor if the resident refuses the procedure. The facility's policy titled Documentation of Medication Administration dated 2001 and last revised 4/2007 documented: The facility shall maintain a medication administration record to document all medications administered. A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). Administration of medication must be documented immediately after (never before) it is given. Documentation must include, as a minimum: name and strength of the drug; dosage; method of administration (e.g., oral, injection (and site), etc.); date and time of administration; reason(s) why a medication was withheld, not administered, or refused (as applicable); signature and title of the person administering the medication; and resident response to the medication, if applicable (e.g., PRN, pain medication, etc.). 1.) R81 is a [AGE] year old resident who was admitted to the facility on [DATE]. R81's diagnoses include Paroxysmal Atrial Fibrillation (an intermittent condition where the upper chambers of the heartbeat chaotically and out of sync which can lead to blood pooling and blood clots) and takotsubo syndrome (sudden temporary weakening of the heart muscle). R81's Physician orders documented Apixaban 5 mg 1 tab by mouth 2 times a day for clotting. Start date 2/20/2026. On 5/19/26 at 12:00 PM, Surveyor reviewed R81's MAR from February 2026 to May 2026. Surveyor noted R81 did not receive Apixaban 5 mg on 5/7/26 at 8:00 PM as ordered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/2026, at 9:53 AM, Surveyor Interviewed Director of Nursing (DON) – B and Regional Nurse (RE)- E regarding missing medications for R81. DON-B expected Nursing staff to sign out the medication as it is given and if it cannot be given the Nurse needs to call the resident' s physician and document why the medication wasn't given and if there were new orders from the resident's physician. RE-E stated the facility will do spot checks to affirm medications are being dispensed as ordered. 2.) R90 is a [AGE] year old resident who was admitted to the facility on [DATE]. R90's diagnoses include Other Venous Thrombosis and Embolism (Blood clots) and Long Term Current Use of Anticoagulants. R90's Physician orders documented Apixaban 5 mg 1 tab by mouth 2 times a day related to personal history of other venous thrombosis and embolism. Start date 3/5/2026. On 5/19/26, at 10:27 AM, Surveyor Interviewed R90. R90 stated they feel like they don't always get all of their medications as prescribed on 2nd and 3rd shifts. R90 denied knowing the names of specific staff that do not give R90 all of the medications ordered. R90 denied knowing what specific medications are missing. On 5/19/26, at 11:30 AM, Surveyor reviewed R90's Medication Administration Record (MAR) from February 2026 to May 2026. Surveyor noted R90 did not receive Apixaban 5 mg on 5/7/26 at 8:00 PM and on 3/9/26 at 8:00 AM as ordered. On 5/20/2026, at 9:53 AM, Surveyor Interviewed Director of Nursing (DON) – B and Regional Nurse (RE)- E regarding missing medications for R90. DON-B expected Nursing staff to sign out the medication as it is given and if it cannot be given the Nurse needs to call the resident' s physician and document why the medication wasn't given and if there were new orders from the resident's physician. RE-E stated the facility will do spot checks to affirm medications are being dispensed as ordered. On 5/20/26, at 10:00 AM, Surveyor shared the concern R90 not receiving ordered Apixaban with Nursing Home Administrator (NHA)-A, DON-B, and RE-E. 3.) R73 was readmitted to the facility on [DATE] with pertinent diagnoses that include cerebrovascular disease (a condition that affects the blood vessels and blood supply to the brain), encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form), aphasia (complete inability or refusal to swallow), tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe (trachea)), and gastrostomy status (a surgically created opening in the abdomen that connects to the stomach, often for the purpose of feeding or administering medication). R73's Quarterly Minimum Data Set (MDS) with an assessment reference date of 4/13/2026, does not document a Brief Interview for Mental Status (BIMS) assessment. The MDS documents that R73 is comatose and has a feeding tube. R73's physician order dated 2/25/2026 documents Truvada Oral Tablet 200-300mg. Give 1 tablet via G-Tube one time a day . R73's progress note dated 3/1/2026 regarding Truvada Oral Tablet documents that the medication (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	05/20/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not available. R73's progress note dated 3/5/2026 regarding Truvada Oral Tablet documents waiting for pharmacy. R73's progress note dated 3/6/2026 regarding Truvada Oral Tablet documents waiting for pharmacy, Director of Nursing (DON)-B, MD (Medical Doctor), pharmacy updated. R73's progress note dated 3/9/2026 regarding Truvada Oral Tablet documents waiting for pharmacy, MD aware. R73's MAR (medication administration record) documents on 2/25/2026, the first day for the medication to be administered, a 5 is documented which indicates to hold the medication. On 2/26/2026, a 9 is documented which indicates other. On 2/28/2026, there is no documentation whether given or not. On 3/1/2026, 3/5/2026, 3/6/2026, and 3/9/2026 for administration the MAR is documented as 9 for other. Surveyor noted six times between 2/25/2026 and 3/9/2026 the MAR was marked with checkmarks indicating the medication was administered, even though other nurses marked the medication as unavailable. On 5/20/26 at 10:13 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-C. Surveyor asked LPN-C what LPN-C does when there is not a medication available for a resident. LPN-C stated If the medication is a stock medication, LPN-C will obtain it from the central supply, if the medication is a prescription, LPN-C will obtain it from the facility's contingency supply and then call the pharmacy to reorder the medication for the resident. Surveyor asked LPN-C , what does LPN-C do if a resident refuses a medication. LPN-C stated, LPN-C will indicate the refusal in the Medication Administration Record (MAR), place resident on the 24-hour board, notify the physician, management, and Power of Attorney (POA) if applicable, and then document in a progress note. On 5/20/2026, at 10:51 AM, Surveyor interviewed DON-B regarding R73's Truvada medication not being available for administration and was told DON-B was not employed by facility at that time and will need to look into. No further information was provided as to why the facility did not ensure that R73's Truvada order was available for administration.

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	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Brown Deer	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not implement effective infection prevention measures to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of communicable diseases and infections for 1 (R53) of 2 residents observed. *Certified Nursing Assistant (CNA)-F did not wear proper personal protective equipment (PPE) while performing peri care on R53 who was in Enhance Barrier Precautions (EBP). The facility's policy and procedure titled, Enhanced Barrier Precautions, implemented 3/25/2024, documents in part: Policy:It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.3. Implementation of Enhanced Barrier Precautions.b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.4. High-Contact resident care activities include.b. Bathing.e. Changing linensf. Changing briefs or assisting with toileting. On 5/20/2026, at 8:06AM, Surveyor observed CNA-F performing peri care and a bed linen change on R53 without wearing a gown. Before entering the room Surveyor observed an EBP sign and cart of PPE supplies. R53's physician order written 3/31/2026 documents EBP- Use enhanced barrier precautions with all high risk cares and activities (refer to sign for guidance)-gloves and gown. On 5/20/2026, at 10:30AM, Surveyor interviewed CNA-G regarding what EBP means when the sign is on the door of a resident room and was told that staff need to wear a gown and gloves when they are doing cares on the resident. On 5/20/2026, at 10:33AM, Surveyor interviewed R53 as to whether staff wear PPE when caring for R53. R53 stated that CNA usually do and nurses always do. R53 pointed out the garbage can under the window for staff to put PPE in when they are done with cares. On 5/20/2026, at 11:17AM, Surveyor interviewed CNA-F regarding what EBP means and CNA-F stated that they messed up during the observation, they should have had a gown on, they were rushing to get it done before wound care and completely forgot. CNA-F stated they apologized to R53 after they realized the mistake. On 5/20/2026, at 11:20AM, Surveyor spoke with Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A and Regional Nurse-E regarding the concern that CNA-F was observed doing peri care on R53 without proper PPE on. No additional information was provided regarding the use of PPE for EBP when providing cares to R53.