STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525533	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Algoma	1510 Fremont St Algoma, WI 54201

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff and resident interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect all 38 residents residing in the facility.The facility did not monitor and document food cooling temperatures.The facility did not test the Quaternary sanitizing solution per manufacturer's instructions.The facility did not ensure each refrigerator contained an internal thermometer to monitor safe food cooling temperatures.The facility did not practice safe food handling processes while serving food.The facility did not monitor the temperature of residents' room refrigerators.Findings include:On 3/23/26, Dietary Manager (DM)-F confirmed the facility follows the Food and Drug Administration (FDA) Food Code.Food Cooling:The 2022 FDA Food Code documents at section 3ˆ501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 Celcuis (C) (135 Fahrenheit (F)) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less .Excessive time for cooling of time/temperature control for safety foods has been consistently identified as one of the leading contributing factors to foodborne illness. During slow cooling, time/temperature control for safety foods are subject to the growth of a variety of pathogenic microorganisms. A longer time near ideal bacterial incubation temperatures, 21 degrees C - 52 degrees C (70 degrees F - 125 degrees F) is to be avoided. If the food is not cooled in accordance with this code requirement, pathogens may grow to sufficient numbers to cause foodborne illness.During a self-guided initial kitchen tour that began at 8:06 AM on 3/23/26, Surveyor observed the following pre-cooked and cooled items in the reach-in cooler:~ A container labeled chicken soup, dated 3/21/26~ A container labeled hamburgers, dated 3/22/26Surveyor observed the following pre-cooked and cooled items in the walk-in freezer:~ A bag labeled goulash, dated 2/23/26~ A bag labeled beef stew, dated 3/3/26~ A container labeled chicken soup, dated 3/12/26During a continuous kitchen observation that began at 7:34 AM on 3/24/26, Surveyor observed the above foods still in the reach-in cooler and walk-in freezer.Surveyor observed the facility's food cooling log and noted the following foods were pre-cooked, cooled, and documented on the log:~ Meatloaf had a final cooking temperature of 171 degrees F on 2/5/26. No further cooling temperatures were documented.~ Baked beans had a final cooking temperature of 201 degrees F on 2/15/26. The cooling start temperature was 162 degrees F. No further cooling temperatures were documented.~ Pureed eggs had a final cooking temperature of 169 degrees F on 2/16/26. The cooling temperature after one hour was 100 degrees F and after two hours was 79 degrees F. No further cooling temperatures were documented.~ Carrots had a final cooking temperature of 188 degrees F on 2/18/26. The cooling temperature after one hour was 170 degrees F and after two hours was 148 degrees F. The last cooling temperature documented was 90 degrees F. No further cooling temperatures were documented.~ Potato soup had a final cooking temperature of 200 degrees F on 2/18/26. The cooling start temperature was 182 degrees F. The cooling temperature after one hour was 150 degrees F and after two hours was 96 degrees F. No further cooling temperatures were documented.~ Stroganoff had a final cooking temperature of 202 degrees F on 2/24/26. The cooling start temperature was 165 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees F and was 91 degrees F after two hours. No further cooling temperatures were documented.~ Meatloaf had a final cooking temperature of 184 degrees F on 2/24/26. The cooling start temperature was 158 degrees F. The cooling temperature after one hour was 140 degrees and after two hours was 76 degrees. No further cooling temperatures were documented.~ Broccoli had a final cooking temperature of 197 degrees F on 2/27/26. The cooling start temperature was 133 degrees F. No further cooling temperatures were documented.~ Mashed potatoes had a final cooking temperature of 172 degrees F on 3/2/26, The cooling start temperature was 170 degrees F. No further cooling temperatures were documented.~ Shepherd's pie had a final cooking temperature of 183 degrees F on 3/9/26. The cooling start temperature was 150 degrees F and was 140 degrees F after one hour. No further cooling temperatures were documented.~ Chicken had a final cooking temperature of 183 degrees F on 3/10/26. The cooling start temperature was 170 degrees F and was 100 degrees F after one hour. No further cooling temperatures were documented.~ Veg had a final cooking temperature of 190 degrees F on 3/10/26. The cooling start temperature was 160 degrees F and was 91 degrees F after one hour. No further cooling temperatures were documented.~ Egg puree had a final cooking temperature of 100 degrees F on 3/12/26. No further cooling temperatures were documented.~ Meatloaf had a final cooking temperature of 188 degrees F on 3/12/26. The cooling start temperature was 114 degrees F. No further cooling temperatures were documented.~ Chicken soup had a final cooking temperature of 190 degrees F on 3/12/26. The cooling start temperature was 150 degrees F and was 74 degrees F after one hour. No further cooling temperatures were documented.~ Chicken soup had a final cooking temperature of 105 degrees F on 3/21/26. No further cooling temperatures were documented.Quaternary Sanitizing Solution:The Hydrion Quaternary test strip package insert directions indicate the test solution should be between 65- and 75-degrees Fahrenheit (F) at the time of testing.During an initial kitchen tour that began at 8:06 AM on 3/23/26, Surveyor observed sanitizing buckets and the three-compartment sink. Surveyor noted the facility's sanitizer documentation log contained the time of day the sink and sanitizing buckets were filled and the PPM. The log did not contain temperature documentation for the sanitizing solution.Surveyor interviewed DM-F who indicated the log can be amended to include the temperature of the sanitizing solution. DM-F confirmed kitchen staff do not obtain and document the temperature of the sanitizing solution for the sanitizing buckets or the three-compartment sink used to clean prep areas and wash dishes.Thermometers in Food Cooling Equipment:The 2022 FDA Food Code documents at 4-204.112 Temperature Measuring Devices: (A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. (B) Except as specified in (C) of this section, cold or hot holding equipment used for time/temperature control for safety food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display . During an initial kitchen tour that began at 8:06 AM on 3/23/26, Surveyor noted the reach-in cooler did not contain an internal thermometer. Surveyor interviewed Dietary Aide (DA)-G who inspected the reach-in cooler and confirmed the cooler did not contain an internal thermometer. DM-F indicated kitchen staff use the thermometer located on the outside of the cooler to monitor the temperature. Surveyor noted the reach-in cooler's outside thermometer indicated the cooler was 52 degrees F.Safe Food Handling:The 2022 FDA Food Code documents at 3-304.15 Gloves, Use Limitation: (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.During an initial kitchen tour that began at 8:06 AM on 3/23/26, Surveyor observed DM-F serve breakfast at the service line. DM-F donned gloves to use throughout meal service and touched plates and serving utensils throughout meal service with the same gloved hands. Surveyor observed DM-F pick up waffles with the same gloved hands and place them on plates for resident consumption. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DM-F plated meals and touched serving spoons, the steam table, and kitchen countertops with the same gloved hands. DM-F also tore a waffle with gloved hands to cut the waffle for a resident. DM-F continued meal service with the same gloved hands and plated another meal for resident consumption. DM-F touched the plate, serving spoons, steam table, and kitchen countertops with the same gloved hands. DM-F then picked up a piece of toast and put the toast on a plate for resident consumption. DM-F did not remove gloves until after the meal service was completed.Refrigerator Temperatures:During an intial tour of the facility on 3/23/26, Surveyors observed personal refrigerators in R8, R2, R3, and R12's rooms. Surveyor did not observe temperature logs in the rooms.On 3/24/26, Surveyor reviewed the facility's Maintenance of Room Refrigerators policy, dated 7/1/25, that indicates the primary purpose of the policy and procedure is to inform staff of the proper procedures to be taken when maintaining company or resident owned refrigerators in the resident's room .1. All resident room refrigerators needs to be maintained in good working condition, monitored for appropriate temperatures and food within, and monitored for safety standards via expiration dating. 2. Resident food stored in room refrigerators must be covered, labeled, and dated. Food must be discarded after three days of the label date by the resident and/or their representative. If not, food will be discarded by housekeeping staff .An internal thermometer will be made available to monitor the temperature. A request for a thermometer can be made to housekeeping staff. Refrigerators must maintain a temperature of 33 to 40 degrees. Temperature checks of room and dayroom refrigerators will be recorded by housekeeping staff daily. Residents and/or their representatives are also responsible for monitoring and maintaining proper temperature and operation .Room and dayroom refrigerators will be checked during housekeeping rounds for cleanliness and appropriate temperatures. Housekeeping will notify the resident if they have outdated food in their room refrigerator that needs to be disposed of and will notify Environmental Services if a refrigerator is not working properly.On 3/24/26 at 7:36 AM, Surveyor interviewed Houskeeper (HSK)-H who stated HSK-H does not check the temperature of residents' refrigerators and does not monitor food in the refrigerators.On 3/24/26 at 7:42 AM, Surveyor interviewed R12 who indicated R12 keeps protein drinks and yogurt in R12's refrigerator. R12 stated staff do not monitor the temperature of the refrigerator.On 3/24/26 at 9:50 AM, Surveyor interviewed R3 who indicated staff do not clean, monitor the temperature, or do any maintenance for R3's refrigerator.On 3/24/26 at 10:00 AM, Surveyor interviewed NHA-A who indicated the facility ordered thermometers for residents' refrigerators and identified housekeeping staff were not monitoring the refrigerators. NHA-A indicated the thermometers were not delivered which was not communicated to NHA-A.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on staff interview and record review, the facility did not ensure a staff person designated as the Infection Preventionist (IP) completed specialized training in infection prevention and control. This practice had the potential to affect all 38 residents residing in the facility.Licensed Professional Nurse (LPN)-C was the facility's designated IP. LPN-C did not complete specialized infection prevention and control training.Findings include:On 3/24/26 at 1:51PM, Surveyor interviewed LPN-C who stated LPN-C had been functioning as the facility's IP since March of 2025. LPN-C verified LPN-C did not complete specialized infection prevention and control training and stated no other staff in the facility are IP certified. LPN-C stated LPN-C completes resident and staff vaccinations and the facility's antibiotic line list but does not have much time to complete other IP-tasks. LPN-C stated the previous Director of Nursing (DON) was certified but no longer works in the facility.On 3/24/26 at 1:56 PM, Surveyor interviewed DON-B who confirmed DON-B did not complete specialized infection prevention and control training and verified the facility does not have a qualified IP. DON-B stated DON-B will complete training in the future to assist with IP duties. On 3/24/26 at 4:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the facility does not have a qualified IP. NHA-A indicated the former DON and IP ended employment with the facility and LPN-C assumed the IP role.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure appropriate weight monitoring was provided for 5 residents (R) (R20, R29, R26, R24, and R15) of 6 sampled residents.R20, R29, R26, R24 and R15 were not re-weighed for weight loss or gain greater than 5 pounds (lbs). R20, R29, R26, R24, and R15's providers and/or representatives were not notified regarding weight loss or gain greater than 5 lbs. In addition, R20, R29, R26, R24 and/or R15's weights were not obtained using a consistent device.Findings include:The facility's Weight Assessment and Intervention policy, revised March 2022, indicates: Resident weights are monitored for undesirable or unintended weight loss or gain. 1. Residents are weighed upon admission and at intervals established by the Interdisciplinary Team. 2. Weights are recorded in each unit's weight record chart and in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. A. If the weight is verified, nursing will immediately notify the dietitian in writing. 4. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss=(usual weight-actual weight)/(usual weight) x 100): a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. If the weight change is desirable, this is documented. 1. Between 3/23/26 and 3/25/26, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had diagnoses including morbid obesity and type 2 diabetes. R20's Minimum Data Set (MDS) assessment, dated 2/14/26, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R29's cognition was severely impaired. R20 had an activated POA.Surveyor reviewed R20's weights and noted the following:~ 3/17/26 at 9:34 PM, 303.0 lbs (mechanical lift) (R20's weight was up 42.6 lbs)~ 3/16/26 at 8:42 PM, 260.4 lbs (mechanical lift) (R20's weight was down 42.2 lbs)~ 3/9/26 at 8:54 PM, 302.6 lbs (mechanical lift)~ 3/2/26 at 9:33 PM, 299.4 lbs (mechanical lift)~ 2/23/26 at 1:38 PM, 295.6 lbs (mechanical lift) (R20's weight down 8.2 lbs)~ 2/16/26 at 10:05 PM, 303.8 lbs (mechanical lift)~ 1/26/26 at 8:42 PM, 303.0 lbs (mechanical lift)~ 1/19/26 at 9:50 PM, 302.4 lbs (mechanical lift) (R20's weight was down 7.8 lbs)~ 1/12/26 at 8:59 PM, 310.2 lbs (mechanical lift)A care plan, dated 11/18/24, indicated R20 had the potential for altered nutrition related to type 2 diabetes, morbid obesity, cognitive communication deficit, and dysphagia. The care plan indicated R20 would have gradual weight loss by 5/9/26 and would accept nutritional supplements as ordered through 5/9/26.R20 had the following orders:~ Weight every Monday (dated 8/18/25)A Nutritional Assessment note, dated 2/14/26, indicated R20's intake average was 75-100%. R20 was started on Remeron for depression which may have appetite stimulant properties. A mini-nutrition assessment of 12 indicated normal nutrition.On 3/24/26 at 2:18 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who indicated staff re-weighed R20 on 3/17/26 and should have documented the weight on 3/17/26 as a re-weigh. LPN-C indicated if a resident's weight is over 100 lbs, a re-weight is required if there is a 5 lb weight variation from the previous weight. LPN-C indicated residents' weights are obtained weekly on their bath day. LPN-C indicated residents with a cardiac diagnosis are weighed based on the provider's order. LPN-C indicated staff noted the stand-up scale was not working in February of 2026 and a new scale was obtained on 3/3/26. LPN-C weighed all residents who use the stand up scale on 3/3/26. LPN-C stated R20's weights should have been accurate as staff used the mechanical lift to weigh R20. LPN-C verified staff should have re-weighed R20 on 1/19/26 and 2/23/26. LPN-C indicated the provider and R20's POA should have notified regarding R20's weight variation of 5 lbs.2. Between 3/23/26 and 3/25/26, Surveyor reveiewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including dementia, heart failure, and multiple sclerosis. R29's MDS (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment, dated 12/27/25, had a BIMS score of 13 out of 15 which indicated R29's cognition was intact. R29 had an activated POA.Surveyor reviewed R29's weights and noted the following:~ 3/11/26 at 10:58 AM, 185.2 lbs (wheelchair) ~ 3/7/26 at 8:46 PM, 182.2 lbs (wheelchair) (R29's weight was up 7 lbs)~ 3/3/26 at 8:42 PM, 175.2 lbs (wheelchair) (R29's weight was up 6.5 lbs) ~ 2/9/26 at 9:03 PM, 168.7 lbs (wheelchair) (R29's weight was down 5.3 lbs) ~ 2/2/26 at 9:10 PM, 174.0 lbs (wheelchair) A care plan, dated 12/22/23, indicated R29 had the potential for altered nutrition related to multiple sclerosis, heart failure, depression, and dementia. The care plan contained interventions to weigh R29 per facility policy or as ordered and notify the provider per order or with significant changes.R29 had the following order:~ Weekly weight every evening shift every Saturday (dated 3/7/26)A progress note, dated 3/2/26, indicated staff were unable to obtain R29's weight because R29 could not safely balance on the standing scale and refused to be weighed in the Hoyer lift. No other functioning scale was available to weigh R29.On 3/24/26 at 2:18 PM, Surveyor interviewed LPN-C who indicated staff should have reweighed R29 on 2/9/26, 3/3/26, and 3/7/26. LPN-C verified R29's weight should be obtained weekly on R29's bath day. LPN-C indicated the provider and R29's POA should have been notified regarding R29's weight variation of 5 lbs.3. Between 3/23/26 and 3/25/26, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] and had diagnoses including obesity and type 2 diabetes. R26's MDS assessment, dated 3/12/26, had a BIMS score of 14 out of 15 which indicated R26's cognition was intact. R26 had a Guardian.Surveyor reviewed R26's weights and noted the following:~ 3/19/26 at 10:29 PM, 231.8 lbs (wheelchair) (R26's weight was down 5.8 lbs) ~ 3/12/26 at 12:15 PM, 237.6 lbs (wheelchair) ~ 3/5/26 at 8:21 PM, 237.6 lbs (wheelchair) (R26's weight was up 29.2 lbs)~ 2/5/26 at 9:01 PM, 208.4 lbs (wheelchair) (R26's weight was down 7.4 lbs)~ 2/5/25 - Weight disputed on 3/17/26 at 5:31 PM/Registered Dietitian disputed value/reassessed~ 1/29/26 at 8:09 PM, 215.8 lbs (standing) ~ 1/22/26 at 9:21 PM, 217.3 lbs (wheelchair) ~ 1/15/26 at 8:48 PM, 220.9 lbs (standing) (R26's weight was down 13.3 lbs) ~ 1/1/26 at 9:57 PM, 234.2 lbs (standing)A care plan, dated 9/15/25, indicated R26 had the potential for altered nutrition related to C-difficile, type 2 diabetes, and obesity. The care plan indicated R26 will have gradual weight loss by 6/4/26, will accept dietary restrictions through 6/4/26, will be weighed per facility policy or as ordered, and staff will notify the provider per order or with significant changes.R26 had the following order:~ Complete weight every Thursday on evening shift (dated 11/13/25)A Nutritional Assessment progress note, dated 3/12/26, indicated R26's current weight was 229 lbs and Body Mass Index (BMI) was 33.7 (class I obesity). The note indicated R26 would benefit from weight loss related to BMI. R26's medical record did not contain progress notes regarding weights or a Registered Dietician note between 12/25/25 and 3/11/26.On 3/24/26 at 2:18 PM, Surveyor interviewed LPN-C who indicated staff should have re-weighed R26 on 1/15/26, 2/5/26, 3/5/26, and 3/19/26. LPN-C indicated R26's weights are obtained weekly on R26's bath day. LPN-C indicated R26's provider and Guardian should have been notified regarding R26's weight variations of 5 lbs. 4. Between 3/23/26 and 3/25/26, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including moderate protein-calorie malnutrition and type 2 diabetes. R24's MDS assessment, dated 1/22/26, had a BIMS score of 14 out of 15 which indicated R24's cognition was intact.Surveyor reviewed R24's weights and noted the following:~ 3/16/26 at 4:52 PM, 175.0 lbs (wheelchair)~ 3/4/26 at 9:52 AM, 170.6 lbs (wheelchair) (R24's weight was up 24.2 lbs)~ 2/9/26 at 9:05 PM, 146.4 lbs (standing) ~ 1/31/26 at 3:17 PM, 148.0 lbs (wheelchair) (R24's weight was down 7 lbs)~ 1/24/26 at 1:26 PM, 155.0 lbs (wheelchair) ~ 1/17/26 at 1:12 PM, 155.8 lbs (mechanical lift) (R24's weight was down 7.6 lbs)~ 1/16/26 at 4:36 PM, 163.4 lbs (mechanical lift) (R24's weight was up 9.2 lbs)~ 1/15/26 at 5:57 PM, 154.2 lbs (wheelchair) A care plan, dated 1/30/26, indicated R24 had the potential for altered nutrition related to surgical amputation, type 2 diabetes, and moderate protein-calorie malnutrition. The care plan contained interventions to include extra protein, weigh R24 per facility policy or as ordered, and notify the provider per order or with significant changes.R24 had the following order:Weekly weight every evening shift every Monday (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(dated 2/7/26)A progress note, dated 3/2/26, indicated R24's weight was not obtained because the facility did not have a functioning wheelchair scale. R24 was a bilateral amputee. A nursing order was obtained to weigh R24 on 3/3/26 with the mechanical lift scale.A progress note, dated 2/8/26, contained a weight warning: 148 lbs on 1/31/26 which was a -7.5% change. The writer suspected a weight error. A Nutritional Assessment note, dated 1/22/26, indicated R24 was at risk for malnutrition. R24's nutrition needs were met via oral intakes. The Registered Dietitian recommended extra dietary protein to promote wound healing.On 3/24/26 at 2:18 PM, Surveyor interviewed LPN-C who verified R24's weights are obtained weekly on R24's bath day. LPN-C indicated staff noted the stand up/wheelchair scale was not working in February of 2026 and a new scale was obtained on 3/3/26. LPN-C indicated a mechanical lift was used to weigh R24 on 1/16/26 and 1/17/26 and staff should have re-weighed R24 and updated the provider if the re-weight was greater than a 5 lb variation. LPN-C indicated staff should have weighed R24 on a mechanical lift scale while the stand up/wheelchair scale was being ordered. LPN-C indicated staff should have documented the variations were due to scale maintenance in R24's progress notes prior to obtaining a new scale. 5. Between 3/23/26 and 3/25/26, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including protein-calorie malnutrition, dementia, Alzheimer's disease, and anorexia. R15's MDS assessment, dated 12/25/25, had a BIMS score of 10 out of 15 which indicated R15 had moderate cognitive impairment.Surveyor reviewed R15's weights and noted the following:~ 3/11/26 at 9:58 AM, 161.4 lbs (wheelchair)~ 3/10/26 at 1:38 PM, 158.0 lbs (wheelchair) (R15's weight was down 5 lbs)~ 3/6/26 at 2:25 PM, 163.0 lbs (wheelchair) (R15's weight was up 5 lbs)~ 3/3/26 at 10:21 AM, 158.0 lbs (standing) (R15's weight was down 6 lbs)~ 2/28/26 at 1:48 PM, 164.0 lbs (standing)~ 2/24/26 at 1:13 PM, 164.0 lbs (standing) (R15's weight was up 9 lbs)~ 2/24/26 at 11:44 AM, 155.0 lbs (standing) (R15's weight was down 10 lbs)~ 2/17/26 at 11:14 AM, 165.0 lbs (mechanical lift) (R15's weight was up 20 lbs)~ 2/10/26 at 11:21 AM, 145.0 lbs (wheelchair)~ 2/3/26 at 2:25 PM, 141.0 lbs (wheelchair) (R15's weigh was down 7 lbs)~ 1/27/26 at 10:31 AM, 148.0 lbs (wheelchair) A care plan, dated 10/18/25, indicated R15 had the potential for altered nutrition related to dementia, weakness, and cognitive communication deficit. The care plan contained interventions for R44 to maintain stable nutrition/weight through 6/17/26, weights per protocol or as ordered, and report changes to Registered Dietitian and provider.R15 had the following order:~ Weekly vitals and weights every day shift every Tuesday (dated 4/8/25)A progress note, dated 2/20/26, indicated R15 had a weight increase of 5% in the past 30 days. R15's weight was stable from November through January and between 150 to 145 lbs. R15 weighed 165 lbs on 2/17/26. R15 was re-weighed with an alternate scale with the same result. A Nutrition Assessment note, dated 12/25/25, indicated R15 weighed 143 lbs. A mini-nutrition assessment score of 11 indicated R15 was at risk for malnutrition.On 3/24/26 at 2:18 PM, Surveyor interviewed LPN-C who indicated R15's weight is obtained weekly on R24's bath day. LPN-C indicated staff should have used a consistent scale and contacted the provider for weight variations greater than 5 lbs as the new scale was obtained on 3/3/26. On 3/24/26 at 2:25 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated a plan of correction regarding residents' weights was started on 2/27/26. DON-B stated DON-B noticed residents' weights were missing and staff were not documenting weights. DON-B provided documentation of staff education on weighing residents and documenting weights. DON-B provided verification of the education with signatures of 5 staff. DON-B indicated Certified Nursing Assistants (CNAs) weigh residents and give the weights to the nurse. The nurse determines if a re-weight is required or if the provider should be notified. On 3/25/26 at 9:56 AM, Surveyor interviewed LPN-C and DON-B. LPN-C indicated R15 should have been re-weighed per the facility's policy. DON-B indicated although a plan of correction was initiated on 2/27/26, following the facility's weight policy is a work in progress. DON-B indicated DON-B and LPN-C are currently monitoring and auditing residents' weights to ensure they are documented accurately and the process is being followed as required. DON-B indicated DON-B is not seeing re-weights completed and providers and resident representatives updated as necessary

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Algoma	1510 Fremont St Algoma, WI 54201

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 4 residents (R) (R44, R3, R35, R5) of 4 sampled residents.R44, R3, R35, and R5 were on enhanced barrier precautions (EBP). Staff did not wear the appropriate personal protective equipment (PPE) during high-contact resident cares. Findings Include: The facility's Enhanced Barrier Precautions policy, dated 3/25/24, indicates: It is the policy of this facility to implement Enhanced Barrier Precautions (EBP) for the prevention of transmission of multi drug-resistant organisms. EBP refers to an infection control intervention designed to reduce transmission of multi drug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high contact care activities .b. An order for enhancement for barrier precautions will be initiated for residents with any of the following .indwelling medical devices .3. Implementation of EBP: make gown and gloves available immediately near or outside the resident's room. b. PPE for EBP is only necessary when performing high-contact care activities .4. High-contact resident care activities include: c. transferring d. providing hygiene. 5. EBP should we followed outside the resident's room .when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. 1. Between 3/23/26 and 3/25/26, Sureyor reviewed R44's medical record. R44 was admitted to the facility on [DATE] and had diagnoses including peritoneal abscess, enterotoxigenic escherichia coli infection, and type 2 diabetes. R44's Minimum Data Set (MDS) assessment, dated 3/24/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R44 had intact cognition. A care plan, dated 3/19/26, indicated R44 was at risk for complications due to an intravenous/peripherally inserted central catheter (IV/PICC) line. The care plan contained an intervention for EBP, dated 3/24/26. R44's medical record contained the following order: ~ Change IV/PICC line dressing every 7 days and as needed using sterile technique. Measure PICC. Every day shift every 7 days (dated 3/18/26) ~ Enhanced barrier precautions every shift (dated 3/24/26) Surveyor reviewed R44's progress notes related to cares that require PPE and noted the following: ~ On 3/18/26, R44 was admitted for IV antibiotics following an abdominal abscess that was drained using a Jackson Pratt (JP) drain (a closed-suction device used to remove excess fluids from surgical sites to prevent infection and reduce swelling) which was removed before discharge. ~ On 3/23/26, R44 had a large emesis. ~On 3/23/26 at 10:30 AM, Surveyor observed an EBP sign on the wall above R44's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~On 3/23/26 at 11:40 AM, Surveyor observed a Certified Nursing Assistant (CNA) enter R44's room, provide a basin, and assist as R44 was vomiting. The CNA entered R44's room without completing hand hygiene or donning PPE and exited the room without completing hand hygiene. ~ From 3/23/36 to 3/25/26, Surveyor did not observe PPE carts outside residents' rooms. On 3/24/25 at 3:39 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C and Director of Nursing (DON)-B. LPN-C indicated R44 was not on EBP. LPN-C stated R44's surgical site was healed and R44 did not have any wounds. When Surveyor asked about the facility's EBP policy and precautions used for intravenous catheters, DON-B indicated R44 had a midline IV in the right arm and should be on EBP. DON-B also indicated staff should use PPE during cares. On 3/25/26 at 10:31 AM, Surveyor observed Physical Therapy Assistant (PTA)-D working with R44. PTA-D was not wearing PPE. PTA-D applied gloves as Surveyor was speaking with R44's Power of Attorney (POA). On 3/25/26 at 10:59 AM, Surveyor interviewed Registered Nurse (RN)-E who stated PPE is kept outside residents' rooms in a cart. RN-E indicated RN-E would have to ask DON-B or another nurse which residents are on EBP since signs aren't always visible outside residents' rooms. RN-E indicated if a resident is on EBP, staff should wear a gown and gloves when providing therapy and assisting with cares. On 3/25/26 at 12:46 PM, Surveyor interviewed PTA-D who was not aware R44 was on EBP. PTA-D stated PTA-D noticed the EBP sign on R44's wall while working with R44 so PTA-D donned gloves. 2. On 3/23/26, Surveyor reviewed R3's comprehensive care plan, revised 2/8/26. The care plan indicated R3 had end stage renal disease and was dependent on hemodialysis. R3 had a permacath (a flexible tube placed into a blood vessel in the upper chest and threaded to the right side of the heart) for hemodialysis. (Of note: R3's medical record did not contain an order for EBP.) On 3/23/26 at 9:44 AM, Surveyor interviewed R3 regarding staff wearing PPE. R3 indicated staff do not wear gowns when providing high-contact cares, only gloves on occasion. Surveyor did not observe an EBP sign inside or outside R3's room and could not locate any gowns in R3's room. On 3/25/26 at 11:14 AM, Surveyor interviewed DON-B regarding EBP for R3. DON-B verified R3 should be on EBP due to the permcath and indicated an order for EBP was added on 3/24/26. 3. On 3/25/26, Surveyor reviewed R35's medical record and noted an order, dated 10/14/25, for EBP. On 3/25/26 at 12:46 PM, Surveyor observed CNA-I and CNA-J transfer R35 into bed with a Hoyer lift. CNA-I and CNA-J adjusted R35's linens without wearing gowns or gloves. (See interview under example 4.) 4. On 3/25/26, Surveyor reviewed R5's medical record and noted an order, dated 11/7/25, for EBP. R5's comprehensive care plan, revised 2/14/26, indicated R5 was at increased risk for infection related to a urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/26 at 11:00 AM, Surveyor observed R5 in R5's room. An EBP sign was posted above R5's bed. On 3/25/26 at 11:07 AM, Surveyor observed CNA-K and CNA-L transfer R5 from a recliner to a wheelchair without wearing gowns or gloves. CNA-L also folded R5's blanket and moved R5's catheter bag to the wheelchair without wearing PPE. On 3/25/26 at 11:14 AM, Surveyor interviewed DON-B who verified staff should wear a gown and gloves during high-contact resident cares.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 5 residents (R) (R18, R22, R24, R30, and R33) of 10 sampled residents were offered influenza/pneumococcal vaccines as indicated.R18 was admitted to the facility on [DATE]. The facility did not obtain R18's consent or declination for the influenza and pneumococcal vaccine.R22 was admitted to the facility on [DATE]. The facility did not obtain R22's consent or declination for the pneumococcal vaccine.R24 was admitted to the facility on [DATE]. The facility did not obtain R24's consent or declination for the influenza and pneumococcal vaccine.R30 was admitted to the facility on [DATE]. The facility did not obtain R30's consent or declination for the influenza and pneumococcal vaccine.R33 was admitted to the facility on [DATE]. The facility did not obtain R33's consent or declination for the influenza and pneumococcal vaccine.Findings include: The facility's Vaccine Policy, revised 10/6/25, indicates: The purpose of this policy is to outline procedures for offering, administering, and documenting vaccines for residents in accordance with Centers for Disease Control and Prevention (CDC) recommendations, Wisconsin Department of Health Services regulations, and applicable state law. Vaccination is a key preventative measure to protect residents from influenza, pneumococcal disease, COVID-19, and Respiratory Syncytial Virus (RSV), which can cause severe illness in older adults .Amethyst Health is committed to: Offering recommended vaccines to all eligible residents; Ensuring informed consent is obtained prior to vaccination; Maintaining accurate vaccine records, resident charts, and facility immunization logs .Upon admission and annually, nursing staff will assess each resident's vaccination status. Staff will provide education regarding benefits, risks, and potential side effects of recommended vaccines .Amethyst Health will use the CDC application PneumoRecs VaxAdvisor to determine the need for further pneumo vaccines.1. Between 3/23/26 and 3/25/26, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation, heart failure, and type 2 diabetes. R18's Minimum Data Set (MDS) assessment, dated 2/15/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R18 had intact cognition. R18's immunization record indicated R18's last influenza vaccine was on 10/8/24.(See interview under example 5.)2. Between 3/23/26 and 3/25/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation, heart failure, and placement of a cardiac pacemaker. R22's MDS assessment, dated 2/19/26, had a BIMS score of 13 out of 15 which indicated R22 had intact cognition. R22's immunization record indicated R22 received a pneumococcal 13 vaccine on 11/9/15 and a pneumococcal 23 vaccine on 10/16/06. The recommended pneumococcal vaccine for R22 based on R22's pneumococcal immunization history: Pneumococcal conjugate 20 or pneumococcal conjugate 21 five years post pneumococcal 13 administration.(See interview under example 5.)3. Between 3/23/26 and 3/25/26, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including frostbite with tissue necrosis of the left and right foot, moderate protein-calorie malnutrition, and type 2 diabetes. R24's MDS assessment, dated 1/22/26, had a BIMS score of 14 out of 15 which indicated R24's cognition was intact. R24's immunization record indicated R24's last influenza vaccine was on 3/5/25.(See interview under example 5.)4. Between 3/23/26 and 3/25/26, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including hepatic encephalopathy, chronic viral hepatitis C, and chronic obstructive pulmonary disease. R30's MDS assessment, dated 1/7/26, had a BIMS score of 9 out of 15 which indicated R30 had moderate cognitive impairment. R30's immunization indicated R30's last influenza vaccination was on 11/9/18. R30 had no history of pneumococcal vaccines.(See interview under example 5.)5. Between 3/23/26 and 3/25/26, Surveyor reviewed R33's medical record. R33 was admitted to the facility on [DATE] and had diagnoses including heart failure, chronic obstructive pulmonary disease, emphysema, and respiratory failure with hypoxia. R33's MDS assessment, dated (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/16/26, had a BIMS score of 12 out of 15 which indicated R33 had moderate cognitive impairment. R33's immunization record indicated R33's last influenza vaccine was on 10/18/22. R33 received the pneumococcal 23 vaccine on 10/26/20 and a pneumococcal conjugate 13 vaccine on 1/23/16. The recommended pneumococcal vaccine for R33 based on R33's pneumococcal immunization history: Pneumococcal conjugate 20 or pneumococcal conjugate 21 five years post pneumococcal 23 administration.On 3/24/26 at 2:35 PM, Surveyor interviewed LPN-C and DON-B. LPN-C indicated the last time residents were offered the influenza vaccine was 10/21/25. LPN-C was not aware of the CDC guidelines and recommendations for pneumococcal vaccination. DON-B indicated DON-B and LPN-C identified residents' immunizations are not current and are in the process of reviewing immunization records. DON-B indicated the facility will offer all vaccines to residents as necessary. LPN-C indicated LPN-C is currently in the process of offering and obtaining consent for vaccines for all residents, including R18, R22, R24, R30, and R33.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 5 residents (R) (R18, R22, R24, R30, and R33) of 10 sampled residents were offered the COVID-19 vaccine.R18 was admitted to the facility on [DATE]. The facility did not obtain R18's consent or declination to receive a COVID-19 vaccine.R22 was admitted to the facility on [DATE]. The facility did not obtain R22's consent or declination to receive a COVID-19 vaccine.R24 was admitted to the facility on [DATE]. The facility did not obtain R24's consent or declination to receive a COVID-19 vaccine.R30 was admitted to the facility on [DATE]. The facility did not obtain R30's consent or declination to receive a COVID-19 vaccine.R33 was admitted to the facility on [DATE]. The facility did not obtain R33's consent or declination to receive a COVID-19 vaccine.Findings include: The facility's Vaccine Policy, revised 10/6/25, indicates: The purpose of this policy is to outline procedures for offering, administering, and documenting vaccines for residents in accordance with Centers for Disease Control and Prevention (CDC) recommendations, Wisconsin Department of Health Services regulations, and applicable state law. Vaccination is a key preventative measure to protect residents from .COVID-19 .which can cause severe illness in older adults .Amethyst Health is committed to: Offering recommended vaccines to all eligible residents; Ensuring informed consent is obtained prior to vaccination; Maintaining accurate vaccine records, resident charts, and immunization logs .Upon admission and annually, nursing staff will assess each resident's vaccination status. Staff will provide education regarding risks, benefits, and potential side effects of recommended vaccines .1. Between 3/23/26 and 3/25/26, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation, heart failure, and type 2 diabetes. R18's Minimum Data Set (MDS) assessment, dated 2/15/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R18's cognition was intact. R18's immunization record indicated R18 last received a COVID-19 vaccine on 10/8/24.R18's medical record did not contain a COVID-19 vaccine consent or declination.(See interview under example 5.)2. Between 3/23/26 and 3/25/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation, heart failure, and placement of a cardiac pacemaker. R22's MDS assessment, dated 2/19/26, had a BIMS score of 13 out of 15 which indicated R22's cognition was intact. R22's immunization record indicated R22 last received a COVID-19 vaccine on 10/28/22.R22's medical record did not contain a COVID-19 consent or declination.(See interview under example 5.)3. Between 3/23/26 and 3/25/26, Surveyor reviewed R24's medical record. R24 was admitted to the facility on [DATE] and had diagnoses including frostbite with tissue necrosis of the left and right foot, moderate protein-calorie malnutrition, and type 2 diabetes. R24's MDS assessment, dated 1/22/26, had a BIMS score of 14 out of 15 which indicated R24's cognition was intact.R24's immunization record indicated R24 had no history COVID-19 vaccines.R24's medical record did not contain a COVID-19 consent or declination.(See interview under example 5.)4. Between 3/23/26 and 3/25/26, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including hepatic encephalopathy, chronic viral hepatitis C, and chronic obstructive pulmonary disease. R30's MDS assessment, dated 1/7/26, had a BIMS score of 9 out of 15 which indicated R30 had moderate cognitive impairment.R30's immunization record indicated R30 last received a COVID-19 vaccine on 5/11/22.R30's medical record did not contain a COVID-19 consent or declination.(See interview under example 5.)5. Between 3/23/26 and 3/25/26, Surveyor reviewed R33's medical record. R33 was admitted to the facility on [DATE] and had diagnoses including heart failure, chronic obstructive pulmonary disease, emphysema, and respiratory failure with hypoxia. R33's MDS assessment, dated 2/16/26, had a BIMS score of 12 out of 15 which indicated R33 had moderate cognitive impairment. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's immunization record indicated R33 last received a COVID-19 vaccine on 12/13/21.R33's medical record did not contain a COVID-19 consent or declination.On 3/24/26 at 2:35 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C and Director of Nursing (DON)-B. LPN-C indicated residents were last offered the COVID-19 vaccine on 10/21/25. DON-B stated DON-B and LPN-C identified residents' immunizations are not current and are in the process of reviewing residents' immunization records. LPN-C indicated LPN-C is in the process of offering and obtaining consent for vaccines for all residents, including R18, R22, R24, R30, and R33.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure adequate monitoring of psychotropic medication was provided for 1 resident (R) (R5) of 5 sampled residents. R5 was prescribed Rexulti (an atypical antipsychotic medication) 0.5 milligrams (mg) once daily for dementia with agitation beginning on 12/18/25. R5's medical record did not include monitoring for adverse reactions or side effects of the antipsychotic medication.The facility's Psychotropic Medication Use policy, dated 8/1/25, indicates antipsychotic medications require monitoring for adverse effects which can include cardiovascular, neurological, and psychosocial effects. On 3/25/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including dementia, diabetes, kidney disease, and hypertension. R5's most recent Minimum Data Set (MDS) assessment, dated 2/14/26, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R5 has severe cognitive impairment. Surveyor reviewed R5's physician orders, Medication Administration Record (MAR), and care plan. R5 had the following physician order: ~ Rexulti 0.5 mg by mouth once daily for one week for dementia with behavior changes then increase to 1 mg daily (start date 12/18/25). The medication was administered as ordered through the date of the survey. R5's medical record did not contain monitoring for adverse reactions or side effects of the medication. Surveyor reviewed the package insert for Rexulti and noted the following potential side effects listed: weight gain, restlessness, sleepiness, dizziness, headache, and increased risk for respiratory infections as well as dementia-related psychosis. On 3/25/26 at 1:03 PM, Surveyor interviewed Director of Nursing (DON)-B regarding monitoring for psychotropic medication. DON-B verified DON-B typically documents adverse reaction/side effect monitoring on a resident's MAR or Treatment Administration Record (TAR) and in the resident's care plan. DON-B verified R5's medical record did not contain monitoring for adverse reactions or side effects of Rexulti.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure a Power of Attorney for Healthcare (POAHC) agreed to a discharge or was notified when 1 resident (R) (R49) of 3 sampled residents was transferred to another skillled nursing facility. R49 was transferred to another skilled nursing facility on 1/7/26. R49's POAHC (POAHC-M) was not notified or contacted prior to the transfer. In addition, R49's medical record did not contain a recapitulation of stay. Findings include: The facility's undated admission Agreement indicates: All transfers or discharges will comply with Wisconsin and federal regulations (42 C.F.R. S483.15 and applicable state codes). The resident may only be transferred or discharged (whether initiated by the facility or resident) for the reasons and under the procedures outlined below .d. In all cases of facility-initiated discharge, the facility will prepare a discharge plan to help ensure a safe and orderly transfer. 4. Discharge Planning and Orientation: The facility will provide sufficient preparation and orientation to the resident to ensure a safe and smooth transfer or discharge. This includes involvement of the resident and representative in discussing discharge options, arranging a post-discharge care plan, and assisting in locating and transferring to an appropriate facility or setting that can meet the resident's needs. The facility's Social Worker or Discharge Planner will work closely on this process . Between 3/23/26 and 3/25/26, Surveyor reviewed R49's medical record. R49 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, diabetes, and right-side paralysis resulting from a cerebral infarction. R49's Minimum Data Set (MDS) assessment, dated 11/4/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R49 had severely impaired cognition. R49 had an activated POAHC (POAHC-M) to assist with medical decisions. R49's medical record contained a note that indicated on 1/7/26 at 10:00 AM, R49 was transferred to another facility via a transportation service. POAHC-M and R49's family were not present. R49's medical record did not contain any other notes related to R49's discharge, including a recapitulation of stay. On 3/24/26 at 12:09 PM, Surveyor interviewed POAHC-M who indicated the facility did not include POAHC-M in any discharge planning meetings for R49. POAHC-M stated POAHC-M did not initiate the transfer of R49 to another facility. POAHC-M stated POAHC-M was interested in the facility but had not started a transfer for R49. POAHC-M did not know R49 was transferred to the facility until POAHC-M received a call on 1/7/26 and was told the transfer had already taken place. POAHC-M stated POAHC-M did not receive a call from anyone at the facility from October 2025 through 1/7/26 regarding a potential transfer to a new facility and did not receive or sign paperwork for the transfer. POAHC-M was not aware of a recapitulation of stay for R49. R49's medical record contained a discharge order signed and dated 1/6/26 by R49's physician. The resident/resident representative signature area of the discharge paperwork was blank. On 3/24/26 at 12:31 PM, Surveyor interviewed Social Services and Admission/Discharge Coordinator (SSADC)-N who stated SSADC-N is supposed to work with the resident or their representative during discharge planning. SSADC-N indicated discharge planning should be a part of the resident's care plan, should be updated as discharge plans change, and should be addressed quarterly during care plan meetings with residents and/or resident representatives. SSADC-N indicated a signed discharge order is obtained from the physician and paperwork is signed by the resident and/or their representative. SSADC-N indicated there should be documentation in R49's medical record regarding discharge communication. SSADC-N verified R49's medical record did not contain discharge communication. SSADC-N confirmed SSADC-N did not contact POAHC-M regarding R49's discharge and did not have POAHC-M sign discharge paperwork. SSADC-N confirmed the facility should have had an accurate discharge plan for R49 with appropriate documentation. SSADC-N indicated SSADC-N dropped the ball on R49's discharge. On 3/25/26 at 2:17 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who acknowledged the discharge process for R49 did not go as it should have and was not done in accordance with the facility's policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525533	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amethyst Health of Algoma	1510 Fremont St Algoma, WI 54201

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	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R11) of 5 sampled residents was free from a significant medication error.R11 did not receive warfarin (a blood-thinning medication) 2.5 milligrams (mg) as ordered from 1/15/26 through 1/18/26 for a total of four missed doses. The facility's Administering Medications policy, revised April 2019, indicates: Medications are to be administered in accordance with prescriber orders .Medication errors are documented, reported, and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee to inform process changes and/or the need for additional staff training. On 3/24/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including dementia, atrial fibrillation, history of stroke, history of deep vein thrombosis, and hypertension. R11's Minimum Data Set (MDS) assessment, dated 2/14/26, indicated R11 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R11 had severe cognitive impairment. R11's comprehensive care plan, dated 9/1/23, indicated R11 received anticoagulant therapy related to atrial fibrillation. The care plan contained interventions to: administer anticoagulant medication as ordered by the physician; obtain labs; inform the physician of the results and follow-up as ordered. R11's January 2026 Medication Administration Record (MAR) indicated warfarin 2.5 mg was administered as ordered from 1/12/26 to 1/14/26. R11's 1/15/26 Internationalized Normalized Ratio (INR) (how long it takes for blood to clot) results were 1.1 seconds. (Of note: The therapeutic range is 2-3 seconds.) A physician fax, dated 1/15/26, contained orders to continue warfarin 2.5 mg daily and recheck R11's INR on 1/19/26. (Of note: From 1/15/26 to 1/18/26, warfarin 2.5 mg was not added to R11's MAR and not administered for 4 days.) R11's 1/19/26 INR results were 1.0 seconds. A nursing progress note, dated 1/19/26, indicated R11's INR was completed and R11 had not received warfarin since 1/14/26. The writer verified with the Assistant Director of Nursing that warfarin was missed from 1/15/26 to 1/19/26. The physician and R11's Power of Attorney (POA) were updated. A Notification to Physician, dated 1/19/26, indicated a medication error occurred and warfarin 2.5 mg was last administered on 1/14/26. The physician indicated to continue warfarin 2.5 mg and check R11's INR on 1/22/26. R11's 1/22/26 INR results were 1.1 seconds.On 3/25/26 at 10:21 AM, Surveyor interviewed Nursing Home Administrator (NHA)- A regarding R11's missed warfarin doses. NHA-A was not aware R11 had missed four doses of warfarin. NHA-A could not provide evidence of staff education related to the medication error or review by the QAPI committee.