STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Brewster Village		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 W Brewster St Appleton, WI 54914	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure adequate supervision and assistance to prevent accidents was provided for 1 resident (R) (R1) of 3 sampled residents.On 2/11/26 at approximately 6:00 AM, R1 had an unwitnessed fall in R1's room and was sent to the emergency room (ER) at approximately 7:00 AM. X-ray results revealed a worsened left humerus fracture, an L1 spinal compression fracture, and a scalp hematoma. On 2/27/26, R1 had surgery to repair the left humerus fracture. The facility's investigation indicated the fall occurred because R1's call light was not in reach and R1 self-transferred to the bathroom. (This example is being cited at past non-compliance.) Findings include:The facility's Fall policy, revised 3/2026, indicates: The focus of care as it relates to falls is to maximize the resident's autonomy, dignity, and self-esteem while trying to reduce falls and injury related to them .fall interventions should be implemented and monitored.On 3/19/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including left humerus (upper arm bone) fracture, adjustment disorder, and weakness. R1's Minimum Data Set (MDS) assessment, dated 2/19/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 discharged from the facility on 3/7/26.An admission Note, dated 2/6/26, indicated R1 was admitted to the facility with an immobilizer on the left arm (due to a recent humerus fracture) and had pain at a level 7 out of 10. R1 had a follow-up appointment on 2/18/26. The note indicated if X-rays did not show improvement, R1 might need shoulder replacement surgery.An admission Fall Risk Assessment, dated 2/6/26, indicated R1 was at risk for falls.A care plan indicated R1 had the potential for falls due to a history of falls and a recent left shoulder fracture. The care plan contained an intervention to ensure R1's call light was within reach.An Incident Note, dated 2/11/26 at 6:45 AM, indicated staff observed R1 on the floor in R1's room at approximately 6:10 AM. R1 complained of pain to the back of the head. R1 was offered pain medication and assisted into bed. A neuro assessment was within normal limits. An immediate intervention was to ensure R1's call light was within reach. Upon review by Registered Nurse (RN)-D, it was determined that Certified Nursing Assistant (CNA)-C did not place R1's call light within reach. RN-D provided education regarding the importance of ensuring call lights are within reach of residents at all times.A Hospital admission Note, dated 2/11/26, indicated R1 sustained a fall at the facility. Repeat imaging revealed a persistent humeral fracture that was possibly more displaced. Staff attempted to control R1's pain with oral medication; however, the pain was intractable and R1 was administered intravenous (IV) pain medication. Left humerus X-ray results, dated 2/11/26, indicated R1 had a comminuted (a severe break where the bone is shattered into three or more pieces) fracture of the neck of the left humerus with lateral displaced proximal fragments.Lumbar spine computed tomography (CT) scan (a noninvasive imaging test that uses X-rays and computers to create detailed 3D images of bones, soft tissue, and blood vessels to diagnose internal injuries) results, dated 2/11/26, indicated R1 had an acute to subacute mild L1 compression fracture (a vertebral collapse at the top of the lumbar spine).A Hospital Discharge Note, dated 2/11/26, indicated R1 had an acute to subacute L1 compression fracture and a possibly increasingly displaced left humeral fracture after (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	recurrent fall upon admission. Orthopedic surgery felt there was no need for a change in care. It was recommended that R1 continue with a sling, have follow-up orthopedic appointments, and use muscle relaxants, lidocaine, and oxycodone for pain control.R1's care plan was updated on 2/11/26 with an intervention for a pendant call light.An Orthopedic Consult Note, dated 2/20/26, indicated R1's X-rays looked worse and left humerus/total shoulder surgery was recommend for the following week. It was recommended that R1 wear a sling at all times.A Hospital Operative Note, dated 2/26/26, indicated R1 had a history of a left shoulder proximal humerus fracture with severe displacement and comminution. Given continued pain and limited motion, R1 chose reverse shoulder arthroplasty with tuberosity fixation (a surgical procedure to replace or resurface a damaged joint using artifical components to relieve severe pain and restore mobility). The risks included bleeding, infection, neurovascular injury, deep vein thrombosis (blood clot), chronic pain, limited motion, weakness, recurrent dislocation, and the need for additional surgery. A Hospital Discharge Note, dated 2/27/26, indicated R1 was treated for a closed 4-part fracture of the proximal humerus with malunion and was to be non-weight bearing to the left upper extremity. It was recommended that R1 wear a sling at all times except for showering and physical therapy.On 3/19/26 at 12:48 PM, Surveyor interviewed CNA-C who verified CNA-C worked with R1 during the night shift from 2/10/26 to 2/11/26 and last saw R1 between 4:30 and 5:30 AM. During CNA-C's last interaction with R1, CNA-C brought R1 to the bathroom and assisted R1 into R1's recliner. CNA-C verified R1's room call light was secured to the bed which was approximately 4 feet from the recliner and out of R1's reach. CNA-C stated CNA-C was educated prior to CNA-C's next shift regarding R1's fall, room call light, and pendant call light. CNA-C was not aware that R1 had a wrist call light on 2/11/26 and did not put it on R1. On 3/19/26 at 8:24 AM, Surveyor interviewed RN-D who stated RN-D was in report at approximately 6:00 AM when a staff received a call from Family Member (FM)-E that R1 had fallen and staff should check on R1. RN-D went to assess R1 and found R1 on the floor. R1 had pain in the left arm. RN-D noted R1's room call light was clipped to the bed and out of R1's reach. R1's wrist call light was in the night stand. RN-D updated the physician and FM-E and sent R1 to the ER for evaluation. RN-D stated R1 consistently used the call light and had not self-transferred any other time during R1's stay.On 3/19/26 at 8:32 AM, Surveyor interviewed FM-E who stated R1 texted FM-E at approximately 6:00 AM that R1 had fallen and needed help. FM-E was not familiar with R1's call light placement but stated R1 was able to use the call light appropriately and make R1's needs known. On 3/19/26 at 9:47 AM, Surveyor interviewed Director of Nursing (DON)-B who verified call lights should be within residents' reach at all times. DON-B stated all residents should have a call light in their room and bathroom and should also have a wrist or pendant call light. DON-B stated R1 initially had a wrist call light but was switched to a pendant call light after the fall. DON-B verified R1's call light was out of reach at the time of the fall. On 3/19/26, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) regarding R1's fall with injury. The investigation indicated R1's pendant call light was in the nightstand and room call light was clipped to the bed and out of R1's reach while R1 was asleep in the recliner. R1 fell when R1 self-transferred to the bathroom. DON-B updated R1's care plan and provided education to all nursing and CNA staff to ensure call lights are in reach at all times. DON-B also completed audits to ensure residents' call lights were within reach.