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 04/15/2026
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not report an allegation of neglect to the State Agency (SA) for 1 resident (R) (R24) of 1 sampled resident.R24 reported an allegation of neglect by Van Driver (VD)-E on 3/13/26. R24 stated VD-E did not use a seatbelt or tie-downs during transport to secure R24's wheelchair in the van. VD-E made an abrupt stop which caused R24 to slide in the wheelchair and suffer rib, back, and lower extremity pain and bruising. The facility did not report the allegation of neglect to the SA.Findings include:The facility's Abuse, Neglect and Exploitation Prohibition policy, revised 7/2025, indicates: At [NAME] Village, each villager has the right to be free from abuse, neglect, and misappropriation of property. Villagers must not be subjected to abuse by anyone or mistreatment by anyone, including but not limited to, facility team members, other villagers, consultants, volunteers, team members of other agencies serving the villager, family members or legal guardians, friends or other individuals. This presumes that instances of abuse of all villagers, even those in a coma, can cause physical harm, pain, or mental anguish .It is the responsibility of all team members to immediately take action and intervene in any and all events to protect the safety and welfare of all villagers .reporting/response.[NAME] Village reports all allegations and substantiated incidents of villager's rights violations to all required agencies.On 4/13/26, Surveyor reviewed R24's medical record. R24 had diagnoses including type 2 diabetes, olecranon bursitis of right elbow, discitis, infection and inflammatory reaction due to internal left knee prosthesis, collapsed vertebra, thoracic region sequela of fracture, and paraplegia. R24's Minimum Data Set (MDS) assessment, dated 3/27/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 had intact cognition.An Incident Note, dated 3/13/26 at 6:52 PM, indicated R24 tipped out of R24's chair during transport back to the facility and reported stiffness throughout the lower back and lower extremities. R24 was offered Tylenol for pain. R24 asked nursing staff to look at R24's ribs which were increasingly sore. The nurse noted no redness, however, R24 expressed discomfort when minimal pressure was applied. R24's right knee was red. R24 indicated the knee could be red due to an ultrasound from a physical therapy appointment; however, the nurse noted red patches above the knee that appeared be burst blood vessels from the incident.A Physician Progress Note, dated 3/17/26 at 10:47 AM, indicated R24 was assessed. The physician noted R24 was in a wheelchair on the way back from an appointment when the van came to a sudden stop. R24 fell forward and hit R24's feet. R24 reported being stiff and sore and had bruising above the right knee.On 4/15/26 at 1:16 PM, Surveyor interviewed Program Manager (PM)-D who indicated PM-D and Director of Nursing (DON)-B discussed the incident when the incident was reported to PM-D and DON-B on the evening of 3/13/26. PM-D and DON-B concluded the incident was not reportable to the SA since there wasn't acute injury at the time. PM-D and DON-B also indicated R24 was sleeping at the time and couldn't be interviewed. PM-D indicated R24 slid forward in the wheelchair due to an abrupt stop at a stop sign. R24 was not wearing seatbelt and R24's wheelchair was not secured to the van via tie-downs. PM-D and DON-B indicated the incident was not considered an allegation of neglect on the part of VD-E and was not reported to the SA.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of neglect was investigated for 1 resident (R) (R24) of 1 sampled resident.R24 reported an allegation of neglect by Van Driver (VD)-E on 3/13/26. R24 stated VD-E did not use a seatbelt or tie-downs during transport to secure R24's wheelchair in the van. VD-E made an abrupt stop which caused R24 to slide in the wheelchair and suffer rib, back, and lower extremity pain and bruising. The facility did not thoroughly investigate the allegation of neglect.Findings include:The facility's Abuse, Neglect and Exploitation Prohibition policy, revised 7/2025, indicates: At [NAME] Village, each villager has the right to be free from abuse, neglect, and misappropriation of property. Villagers must not be subjected to abuse by anyone or mistreatment by anyone, including but not limited to, facility team members, other villagers, consultants, volunteers, team members of other agencies serving the villager, family members or legal guardians, friends or other individuals .It is the responsibility of all team members to immediately take action and intervene in any and all events to protect the safety and welfare of all villagers .[NAME] Village conducts a thorough investigation of all villager-related incidents and allegations of villagers' rights violations. Upon completion of these investigations, reports are filed in compliance with current regulations .On 4/13/26, Surveyor reviewed R24's medical record. R24 had diagnoses including type 2 diabetes, olecranon bursitis of right elbow, discitis, infection and inflammatory reaction due to internal left knee prosthesis, collapsed vertebra, thoracic region sequela of fracture, and paraplegia. R24's Minimum Data Set (MDS) assessment, dated 3/27/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 had intact cognition. An Incident Note, dated 3/13/26 at 6:52 PM, indicated R24 tipped out of a wheelchair during transport and reported stiffness throughout the lower back and lower extremities. R24 was offered Tylenol for pain. R24 asked nursing staff to look at R24's ribs which were increasingly sore. The nurse noted no redness, however, R24 expressed discomfort when a minimal amount of pressure wa applied. R24's right knee was red. R24 indicated the knee could be red due to an ultrasound from a physical therapy appointment; however, the nurse noted red patches above the knee that appeared to be burst blood vessels from contact during the incident. A Physician Progress Note, dated 3/17/26 at 10:47 AM, indicated R24 was assessed. The physician noted R24 was in a wheelchair on the way back from an appointment when the van came to a sudden stop. R24 fell forward and hit R24's feet. R24 reported being stiff and sore and had bruising above the right knee.On 4/14/26, Surveyor reviewed the facility's incident report and investigation and noted the following:~ The facility did not interview R24 until 3/16/26. The facility did not monitor R24's right knee bruise or complete pain assessments for R24's rib, back, and lower extremity pain. ~ The facility did not interview VD-E until 3/16/26. The investigation did not contain a statement of VD-E's account of the incident. In addition, facility did not remove VD-E from driving the van pending the outcome of the investigation. (The Maintenance Director sent an email to Program Manager (PM)-D on 3/16/26 that indicated VD-E admitted VD-E did not secure R24's wheelchair in the van. VD-E's account of the incident was not documented.)~ The facility did not interview residents who use the van for transportation to see if they had similar experiences.~ The facility did not provide staff education (for others who drive the van) on the facility's safe transportation or abuse/neglect policy and procedure.On 4/15/26 at 1:16 PM, Surveyor interviewed PM-D and Director of Nursing (DON)-B. PM-D verified PM-D completed the investigation for the incident that occurred on 3/13/26. PM-D and DON-B discussed the incident and concluded since there was no acute injury at the time and R24 was sleeping and could not be interviewed, an internal investigation would be completed when R24 was available to interview. PM-D and DON-B indicated VD-E was interviewed following the incident and was educated on the facility's safe transportation and abuse/neglect policies and procedures. VD-E was also assigned Relias training regarding safe transport. Surveyor requested training documentation for VD-E. Surveyor did not (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive documentation that indicated VD-E received training following the incident. DON-B stated R24 was assessed at the time of the incident and had no injuries. DON-B was not aware that R24 reported pain and discomfort and stated DON-B would check if assessments were completed. Surveyor did not recieve pain or skin assessments or documentation indicating the bruise on R24's right knee was monitored.

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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 - Minimal harm or potential for 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 and resident interview and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R24) of 7 sampled residents.R24 reported that Van Driver (VD)-E did not use tie-downs or a seatbelt to secure R24's wheelchair in the van during transport on 3/13/26. VD-E made an abrupt stop which caused R24 to slide in the wheelchair and resulted in rib, back, and lower extremity pain and bruising to R24's knee. Findings include:The facility's [NAME] Village Van Use (Non-Emergent Transportation) policy, revised 3/2026, indicates: To assign responsibility and coordinate use of the van .Department Leaders, Health Information Associates, and Van Drivers .2. For safety reasons .Non-certified staff are not to boost, hoist, lift, or transfer villagers. In the event there is a questionable issue during transportation, the driver is to call the Building Supervisor. Staff and villagers are required to always use seat belts. If for any reason a villager refuses or removes a safety device during transport, the driver is to call the Building Supervisor and stop transport. Transportation will not be provided if the villager refuses to wear safety equipment. The wheelchair restraint system is to always be used for transportation of villagers who are in wheelchairs, powered wheelchairs, or Broda chairs .On 4/13/26, Surveyor reviewed R24's medical record. R24 had diagnoses including type 2 diabetes, olecranon bursitis of right elbow, discitis, infection and inflammatory reaction due to internal left knee prosthesis, collapsed vertebra, thoracic region sequela of fracture, and paraplegia. R24's Minimum Data Set (MDS) assessment, dated 3/27/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R24 had intact cognition.On 4/13/26 at 10:20 AM, Surveyor interviewed R24 who indicated R24 was injured on 3/13/26 while being transported to a medical appointment. R24 stated R24 does not require a seatbelt, refuses to wear a seatbelt, and has been transported in the facility's van multiple times per week without a seatbelt. R24 stated R24 was routinely secured in the van with wheelchair tie-downs; however, VD-E did not secure R24's wheelchair with tie-downs and R24 was not wearing a seat belt during transport on 3/13/26. R24 stated VD-E made an abrupt stop at a stop sign and R24 slid out of the chair. R24 hit a tool box on the floor of the van, hit R24's right knee, and jammed R24's toes. R24 was assisted back into the wheelchair and brought back to the facility. R24 reported soreness and stiffness in the legs and back, achy ribs, and a swollen knee. A nurse assessed R24. R24 expressed frustration with the facility's follow-up and stated no one from administration spoke to R24 until 3/16/26. R24 was unsure if an investigation was completed. R24 expressed frustration with the assessment of R24's ribs, knee, legs, and back and stated R24 pain and had a swollen knee which concerned R24.An Incident Note, dated 3/13/26 at 6:52 PM, indicated R24 tipped out of a wheelchair during transport and reported stiffness throughout the lower back and lower extremities. R24 was offered Tylenol for pain. R24 asked nursing staff to look at R24's ribs which were increasingly sore. The nurse noted no redness, however, R24 expressed discomfort when minimal pressure was applied. R24's right knee was red. R24 indicated the redness could be due to an ultrasound from a physical therapy appointment; however, the nurse noted red patches above the knee that appeared to be burst blood vessels from contact during the incident. A Physician Progress Note, dated 3/17/26 at 10:47 AM, indicated R24 was assessed. The physician noted R24 was in a wheelchair on the way back from an appointment when the van came to a sudden stop. R24 fell forward and hit R24's feet. R24 reported being stiff and sore and had bruising above the right knee.On 4/16/26 at 10:49 AM, Surveyor interviewed VD-E who stated while transporting R24 to a medical appointment on 3/13/26, R24 dictated the route VD-E should take. VD-E stated VD-E did not know the area well and was driving slowly in the van. VD-E stated VD-E did not feel comfortable transporting residents and abruptly stopped at a stop sign while going approximately 5-7 miles per hour. VD-E stated R24 shifted from the wheelchair which required VD-E to put VD-E's arms under R24's arms and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reposition R24 in the wheelchair. VD-E verified R24 was not wearing a seatbelt and was not secured in the van with wheelchair tie-downs. VD-E verified VD-E should not reposition residents which was a reason VD-E was uncomfortable transporting residents. VD-E stated R24 did not fall out of the wheelchair seat but reported soreness in the legs and chest. VD-E brought R24 back to the facility and informed management of the incident. VD-E stated VD-E was hired as a member of the maintenance crew and was unaware the position required VD-E to regularly trasport residents in the van. VD-E indicated VD-E had not previously worked with residents. VD-E stated the training VD-E received prior to transporting residents consisted of shadowing transportations with other members of maintenance and Facility Operations Manager (FOM)-C. VD-E then transported residents with other staff present and eventually transported residents alone. VD-E stated VD-E was informed during training that R24 refused to wear a seatbelt. VD-E was told not to use the seatbelt because R24 would refuse. VD-E stated if VD-E had to use tie-downs for a wheelchair VD-E was unfamiliar with, VD-E had to use a chart to learn how to use tie-downs to secure the wheelchair. VD-E stated VD-E received Relias training (the facility's online training system) on van transportation and safety on 4/13/26. VD-E felt VD-E should have received the training prior to transporting residents. VD-E indicated no other training was provided following the incident on 3/13/26.On 4/16/26 at 1:16 PM, Surveyor interviewed FOM-C who stated the facility has a van driver and maintenance staff also transport residents. FOM-C indicated hands-on training is provided during ride alongs to show and explain how restraints work. FOM-C stated when the trainee is comfortable with the process, the trainee completes ride alongs as the driver a few times before completing transports independently. FOM-C confirmed there is not a skills demonstration check list to indicate the trainee can demonstrate the skills and understands the transportation policy and procedure. FOM-C indicated seatbelts and wheelchair tie-downs should be used during all transports and secured prior to transport. FOM-C was not aware R24 refused to wear a seatbelt during transport. During the interview with FOM-C, Program Manager (PM)-D was present and indicated VD-E received training on the facility's safe transportation of residents and abuse/neglect policies as well as Relias training on safe transport of residents following the incident. Surveyor requested training documentation for VD-E as well as other staff who drove the van. The documentation was not provided. FOM-C indicated the safety plan going forward included an agreement that R24 would wear all safety belts during transport. FOM-C stated FOM-C updated the facility's van transportation policy after the incident to indicate all residents need to be secured before transportation which will not take place if the resident is not secured. If the resident refuses, transportation will not occur and staff will call the supervisor for direction.