

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  01/08/2025
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)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51043</p> <p>Based on observation, resident and staff interview, and record review, the facility did not ensure 1 resident (R) (R99) of 1 sampled resident was able to be informed of and participate in medical treatment/medical decisions in a language R99 could understand.</p> <p>R99's primary language was Spanish. R99 indicated a preference for staff to use interpreter services to ensure R99 could communicate medical treatment needs. Interpreter services were not consistently provided. In addition, R99's care plan did not address R99's language barrier.</p> <p>Findings include:</p> <p>The facility's undated Communication with Sensory Impaired Villagers policy indicates: .Interpreters and auxiliary aids will be provided at no cost to the villager. Villagers requiring an interpreter or an auxiliary aid should indicate to our staff that these services are required .Upon admission or as the need arises, the Minimum Data Set (MDS) Coordinator or the Social Worker shall assess the need for special communication provisions to sensory-impaired individuals, and document any need in the medical record .Upon initial review of the medical record, the Social Worker shall assist the villager and/or family members, and arrange for special communication provisions as desired .</p> <p>The facility's Care Planning Procedure policy, dated 10/2024, indicates: .care plan is developed that includes measurable objectives and time tables to meet the villager's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment .Each individual has the right to determine the care and treatment they wish for themselves .Aspects of villager life for the team to discuss and consider for care plan approaches will include, but not be limited to: Personal Care .Dietary/Cultural preferences . Communication/memory .</p> <p>On 1/6/25, Surveyor reviewed R99's medical record. R99 was admitted to the facility on [DATE] and had diagnoses including acute kidney failure, chronic respiratory failure, type 2 diabetes, end stage renal disease, and dependence on renal dialysis. R99's MDS assessment, dated 10/24/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R99 was not cognitively impaired. R99's MDS assessment, dated 10/30/24, indicated R99's preferred language was Spanish and R99 preferred an interpreter to communicate with a doctor or healthcare staff. R99 was responsible for R99's healthcare decisions.</p> <p>R99's care plan did not address communication including the need for an interpreter or list the language that R99 understood.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525574
		If continuation sheet Page 1 of 15

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Social Services progress note, dated 7/16/24 (prior to admission), indicated R99 spoke Spanish and an interpreter would be needed as appropriate.</p> <p>A Social Services progress note, dated 10/24/24, indicated the Social Worker spoke with R99 through R99's cousin (as a translator) when R99 returned from a medical appointment.</p> <p>A Social Services progress note, dated 11/15/24, indicated the Social Worker spoke with R99 through R99's cousin's wife (who served as a translator) regarding Medicaid liability.</p> <p>In addition, multiple nursing progress notes from 7/16/24 through 11/15/24 indicated there was a communication barrier as R99 spoke Spanish and minimal English. The notes indicated R99 could answer basic questions and did well with gestures.</p> <p>On 1/7/25 at 1:01 PM, Surveyor interviewed R99 via a Spanish interpreter. Through the interpreter, R99 indicated R99 had difficulty communicating R99's needs to staff. R99 indicated R99's daughter communicated R99's needs to staff, however, R99's daughter was not always available to help. R99 indicated when R99 was admitted to the facility staff offered the use of an interpreter, however, staff don't offer an interpreter anymore. R99 indicated R99 primarily communicates with gestures or very simple questions from staff but preferred staff use an interpreter so R99 could understand and communicate better. R99 indicated R99 tried to communicate to staff that R99 needed medication for itchiness but was not successful. R99 stated R99's daughter puts cream on R99's itchy back but does not come daily to apply the cream and R99 is still itchy. R99 indicated staff did not inform R99 how to request an interpreter. R99 reiterated a second time that R99 preferred staff use an interpreter instead of waiting for R99's daughter to translate. R99 stated when R99 tried to tell staff that R99 disliked a breakfast food, staff gave R99 more of the food R99 disliked. R99 indicated that occurred because because R99 could not communicate R99's likes and dislikes to staff.</p> <p>On 1/7/25 at 1:01 PM, Surveyor observed a piece of paper with an interpreter contact number taped on R99's closet door approximately 5 feet off the ground which was above the line of sight for R99 who was wheelchair bound.</p> <p>On 1/7/25 at 2:13 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated when R99 wakes up at 7:00 or 7:15 AM, staff bring hygiene supplies. CNA-F indicated CNA-F would use an interpreter if CNA-F did not understand R99, however, R99 could speak a little English and use gestures to communicate. CNA-F indicated there was an interpreter phone number on the phone that CNA-F carried. CNA-F indicated if staff did not understand R99, an interpreter would be called.</p> <p>On 1/7/25 at 3:03 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R99 was able to communicate with staff via simple questions and answers. DON-B indicated more complex things were translated through R99's daughter. DON-B stated staff have access to an interpreter on the facility's phones. DON-B indicated nurses complete assessments for R99 by asking simple questions. Surveyor informed DON-B that R99 complained of itchiness that R99 was not able to communicate to nursing staff. DON-B indicated R99 should be able to initiate a conversation with staff. DON-B confirmed R99's care plan did not address a language barrier.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43361</p> <p>Based on observation and staff interview, the facility did not ensure call lights were within reach for 3 residents (R) (R80, R83, and R93) of 4 sampled residents.</p> <p>During multiple observations between 1/6/25 and 1/8/25, R80 did not have a call light within reach.</p> <p>On 1/8/25, R83 was observed without a call light within reach.</p> <p>On 1/6/25, R93 was observed without a call light within reach.</p> <p>Findings include:</p> <p>The facility did not have a policy on ensuring call lights were within reach of residents.</p> <p>1. From 1/6/25 to 1/8/25, Surveyor reviewed R83's medical record. R83 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, generalized anxiety disorder, major depressive disorder, and encounter for palliative care. R83's Minimum Data Set (MDS) assessment, dated 10/29/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R83 had moderately impaired cognition.</p> <p>R83's activities of daily living (ADL) care plan contained an intervention (dated 3/8/23) that indicated: I use the following notification devices: wall call light</p> <p>On 1/6/25 at 9:53 AM, Surveyor observed R83 in bed asleep. Surveyor noted R83's call light was wrapped around the lower rail of R83's bed and hung toward the floor. Surveyor noted had bilateral hand contractures.</p> <p>On 1/7/25 at 10:57 AM, Surveyor observed R83 in bed covered with blankets with R83's hands exposed. R83's call light was wrapped around a bed rail and hung toward the floor. When Surveyor asked if R83 could reach the call light, R83 said no. When Surveyor asked what R83 would do if R83 needed help, R83 indicated R83 didn't know. When asked if R83 wanted the call light within reach, R83 said yes. Surveyor then exited R83's room and found Registered Nurse (RN)-I who verified R83's call light was not within reach. RN-I indicated R83's call light should be within reach. RN-I indicated Hospice staff just gave R83 a shower and probably forgot to give R83 the call light. Surveyor informed RN-I of Surveyor's observation on 1/6/25 when R83's call light was also not within reach. RN-I indicated RN-I would provide education.</p> <p>On 1/8/25 at 9:00 AM, Surveyor observed R83 in bed and noted R83's call light was again wrapped around the lower rail of the bed and hung toward the floor out of R83's reach.</p> <p>On 1/8/25 at 9:02 AM, Surveyor showed Certified Nursing Assistant (CNA)-J R83's call light. CNA-J verified R83 was unable to reach the call light. CNA-J indicated R83's hands were so contracted that CNA-J did not think R83 could push the call light. When Surveyor asked if a soft touch call light had been tried with R83, CNA-J didn't think so but stated CNA-J would ask.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. From 1/6/25 to 1/8/25, Surveyor reviewed R80's medical record. R80 was admitted to the facility on [DATE] and had diagnoses including aphasia, cerebral infarction due to thrombosis of right middle cerebral artery, vascular dementia, and hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) following cerebral infarction affecting the left non-dominant side. R80's MDS assessment, dated 10/22/24, indicated R80 was severely cognitively impaired.</p> <p>R80's ADL care plan contained an intervention (dated 6/10/21) that indicated: I use the following notification devices: wall call light.</p> <p>On 1/8/25 at 9:00 AM, Surveyor observed R80 in a Broda chair in R80's room. R80's call light was wrapped around the lower rail of R80's bed approximately 3 feet from R80's Broda chair. R80 was not able to mobilize R80's self in the chair and was unable to answer Surveyor's questions.</p> <p>On 1/8/25 at 9:02 AM, Surveyor interviewed CNA-J who confirmed R80's call light was out of reach. When CNA-J gave R80 the call light, R80 pushed the call light repeatedly. CNA-J indicated R80 did not know how to use the call light. When Surveyor asked CNA-J to place the call light in R80's lap, R80 picked up the call light and pushed it. Surveyor asked CNA-J if the facility had tried a soft touch call light or other type of call light. CNA-J did not know.</p> <p>On 1/8/25 at 11:10 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did not have a policy regarding call light access and indicated it was a standard of care for residents to have call lights within reach. DON-B indicated the facility had different options for call lights. If a resident isn't mobile, DON-B indicated DON-B expects a resident's call light to be within reach despite the resident's cognitive level.</p> <p>50479</p> <p>3. From 1/6/25 to 1/8/25, Surveyor reviewed R93's medical record. R93 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia and left-sided hemiplegia (weakness on one side of the body). R93's MDS assessment, dated 8/21/24, indicated R93 had moderate cognitive impairment. R93's most recent MDS assessment did not contain a BIMS assessment.</p> <p>R93's care plan, dated 7/6/23 with a goal of 2/11/25, stated, I have potential for falls .ensure my call light is within reach.</p> <p>On 1/6/25 at 10:52 AM, Surveyor observed R93 in a chair in R93's room. Surveyor noted R93's call light was hanging next to R93's bed which was across the room and not within R93's reach.</p> <p>On 1/6/25 at 10:57 AM, Surveyor interviewed CNA-K who confirmed R93's call light was not within reach and placed the call light within reach of R93.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51043</p> <p>Based on staff interview and record review, the facility did not ensure a physician was notified of a change in condition for 1 resident (R) (R56) of 7 sampled residents.</p> <p>R56's physician was not notified of skin wounds until 7 days after the wounds were discovered.</p> <p>Findings include:</p> <p>The facility's Notification of Change in Condition/Treatment policy, dated 2/2024, indicates: .Significant changes in the villager's physical, mental, or psychosocial status, or accidents/other incidents shall be reported to the Physician/Nurse Practitioner by the Licensed Nurse .the date, time, and who was notified shall be documented in the villager's medical record .</p> <p>On 1/6/25, Surveyor reviewed R56's medical record. R56 was admitted to the facility on [DATE] and had diagnoses including urinary tract infection (UTI), neurocognitive disorder with Lewy bodies (a form of progressive dementia that affects a person's ability to think, reason, and process information), dementia, type 2 diabetes, and erythema intertrigo (a type of skin rash). R56 had an activated Power of Attorney for Healthcare (POAHC) who was responsible for R56's medical decision-making. R56's Minimum Data Set (MDS) assessment, dated 11/27/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R56 had moderate cognitive impairment.</p> <p>R56's medical record contained nursing progress notes that indicated R56 had 2 small skin shearing areas on the coccyx that were identified on 11/26/24. The nurse initiated barrier cream, a pressure reducing pad on R56's bed and chair, and frequent turning/repositioning.</p> <p>A nursing assessment, dated 11/26/24. indicated the wounds were moisture-associated skin damage (prolonged exposure to excessive moisture) most likely due to urinary and/or stool incontinence. A different barrier cream was ordered and a task was initiated to update the wound team if the wounds worsened.</p> <p>A nursing assessment, dated 12/2/24, indicated the wounds were unstageable pressure injuries. The physician was updated regarding the wounds and treatment plan.</p> <p>On 1/8/25 at 12:15 PM, Surveyor interviewed wound care certified Registered Nurse (RN)-G who verified R56 had preventative skin impairment measures implemented upon admission, including a cushion in R56's chair and repositioning every 2 hours in bed and every hour in chair. RN-G verified the wounds on R56's coccyx were identified on 11/26/24. RN-G verified R56's physician was not notified until 12/2/24 when the wounds were diagnosed as unstageable. RN-G indicated the physician should have been notified when the wounds were discovered on 11/26/24.</p> <p>On 1/8/25 at 1:27 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the physician should have been notified of R56's wounds on 11/26/24.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>50988</p> <p>Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R10) of 3 sampled residents received the necessary care and treatment for oxygen therapy.</p> <p>R10 had a physician order for 2-6 liters per minute (LPM) of oxygen and used oxygen continuously. R10 did not have a care plan for oxygen use. In addition, R10's oxygen tubing was not changed after R10 was diagnosed with pneumonia.</p> <p>Findings include:</p> <p>The facility's undated Changing of Disposable Respiratory Supplies policy indicates: Nasal cannula and oxygen tubing: Change when device becomes soiled, discolored, stiff or every 3 months. Discard if resident recently had a respiratory infection.</p> <p>From 1/6/25 to 1/8/25, Surveyor reviewed R10's medical record. R10 had diagnoses including congestive heart failure (CHF), dementia, and pneumonia. R10's Minimum Data Set (MDS) assessment, dated 2/2/24, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R10 had severe cognitive impairment.</p> <p>R10 had a physician order, dated 10/23/24, for 2-6 LPM of oxygen via nasal cannula.</p> <p>R10's medical record did not contain a care plan for oxygen use.</p> <p>R10's medical record indicated R10 was diagnosed with pneumonia on 10/23/24 and had orders for a chest X-ray, antibiotics, and oxygen.</p> <p>R10's medical record did not contain documentation that indicated R10's nasal cannula and oxygen tubing were changed from 10/24/24 to 1/6/25 even though the facility's policy indicated respiratory devices should be discarded if a resident had a recent respiratory infection.</p> <p>On 1/6/25 at 9:35 AM, Surveyor observed R10 using oxygen at 2 LPM via nasal cannula.</p> <p>On 1/7/25 at 9:01 AM, Surveyor interviewed Registered Nurse (RN)-E who indicated R10's medical record did not indicate when R10's oxygen tubing was last changed. RN-E indicated there should be documentation on R10's Treatment Administration Record (TAR) to verify when oxygen tubing is changed.</p> <p>On 1/8/25 at 11:24 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R10 should have had a care plan for oxygen therapy and indicated a care plan was added on 1/7/25. DON-B indicated residents' oxygen tubing should be changed every 7 days and with a respiratory infection.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51043</b></p> <p>Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R99) of 1 resident received appropriate dialysis care and services.</p> <p>R99 received dialysis services. R99 did not have a dialysis care plan to ensure coordination of care and monitoring of R99's fistula (a surgically created connection between an artery and a vein in the arm).</p> <p>Findings include:</p> <p>The facility's Dialysis Coordination policy, dated 6/2024, indicates: Each villager that has outpatient dialysis services will be monitored for risk factors and complications which may include .Access Site Monitoring: . Nursing will .initiate hemodialysis (HD) care plan .</p> <p>On 1/6/25, Surveyor reviewed R99's medical record. R99 was admitted to the facility on [DATE] and had diagnoses including acute kidney failure, chronic respiratory failure, type 2 diabetes, end stage renal disease, and dependence on renal dialysis (blood purifying treatment given when kidneys are not functioning). R99 was responsible for R99's healthcare decisions. R99's Minimum Data Set (MDS) assessment, dated 10/24/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R99 did not have impaired cognition.</p> <p>On 1/6/25 at 1:30 PM, Surveyor interviewed R99 (with R99's daughter interpreting). R99 indicated staff did not consistently assist R99 with personal hygiene prior to leaving the facility for dialysis. R99 indicated R99 still had on pajama pants because R99 did not receive assistance that day which was a dialysis day.</p> <p>On 1/7/25 at 12:37 PM, Surveyor reviewed R99's plan of care, dated 7/16/24, which did not contain a dialysis care plan and did not indicate R99 attended dialysis or had a right arm fistula. The care plan indicated R99 needed help with daily hygiene in the morning including set-up with oral care and assistance with dressing.</p> <p>On 1/7/25 at 1:01 PM, Surveyor interviewed R99 via a Spanish interpreter service. R99 indicated dialysis staff monitor R99's fistula, but facility staff do not.</p> <p>On 1/7/25 at 3:30 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R99's plan of care should include dialysis and fistula monitoring. DON-B indicated Certified Nursing Assistants (CNAs) should know when R99 has dialysis appointments and should know not to check R99's blood pressure on the right arm due to R99's fistula.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51043</p> <p>Based on observation, staff and resident interview, and record review, the facility did not provide pharmaceutical services to meet the needs of 1 resident (R) (R99) of 29 sampled residents.</p> <p>On 1/7/24 at approximately 2:00 PM, Surveyor observed a tube of 1% hydrocortisone (anti-itch cream) cream on a shelf under R99's refrigerator.</p> <p>Findings include:</p> <p>The facility's undated Self-Administration of Medications by Residents policy indicates: .If the resident desires to self-administer medication, an assessment is conducted by the Interdisciplinary Team .If the resident demonstrates the ability to safely self-administer medication, a further assessment of the safety of bedside medication storage is conducted .The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if unlocked storage is ineffective .The beside medication record is reviewed on each nursing shift, and the administration information is transferred to the Medication Administration Record (MAR) kept at the nursing station. Notation of each self-administered dose is made by placing a check mark in the appropriate space .</p> <p>On 1/6/25, Surveyor reviewed R99's medical record. R99 was admitted to the facility on [DATE] and had diagnoses including acute kidney failure, chronic respiratory failure, type 2 diabetes, end stage renal disease, and dependence on renal dialysis (blood purifying treatment given when kidneys are not functioning). R99's Minimum Data Set (MDS) assessment, dated 10/24/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R99 did not have impaired cognition. R99 was responsible for R99's medical decision-making</p> <p>On 1/7/25 at 1:01 PM, Surveyor interviewed R99 and R99's daughter. R99 indicated via a Spanish interpreter that R99 needed an ointment. R99's daughter indicated R99 complained of an itchy back and R99's daughter applied Vasoline or a prednisone-like cream that was kept under R99's refrigerator when R99's daughter visited, including yesterday.</p> <p>On 1/7/25 at approximately 2:00 PM, Surveyor observed an open tube of 1% hydrocortisone cream on a shelf under R99's refrigerator.</p> <p>On 1/7/25 at approximately 2:30 PM, Surveyor reviewed R99's medical record which did not contain a self-administration of medication assessment or a medication storage assessment.</p> <p>On 1/7/25 at 3:51 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R99 did not have a self-administration of medication assessment, therefore, no medications should be in R99's room.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45942</p> <p>Based on staff interview and record review, the facility did not ensure adequate monitoring for 1 resident (R) (R47) of 5 residents reviewed for psychotropic medications.</p> <p>R47 was prescribed diazepam (an antianxiety medication), quetiapine fumarate (an antipsychotic medication), and mirtazapine (an antidepressant medication). R47's medical record did not contain monitoring interventions for adverse reactions to the psychotropic medications.</p> <p>Findings include:</p> <p>The facility's undated Psychotropic Drug Monitoring policy indicates: Psychotropic medication is any medication that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to .antipsychotic, antidepressant, antianxiety, and hypnotic .Residents who receive psychotropic medications are monitored to evaluate the effectiveness of the medication. Every effort is made to ensure the residents receiving these medications obtain the maximum benefit with the minimum of untoward effects. Procedure: .Effects of the medications are documented as a part of the care planning process .4) The need for and response to therapy are monitored and documented in the resident's medical record .Psychotropic drug monitoring guidelines include but may not be limited to: Antianxiety/Sedative Drugs: .2) Behavioral monitoring charting or similar mechanisms are used to document the resident's need for and response to drug therapy. Antidepressants: .3) The resident's subjective and/or objective improvement or maintenance of function is documented. 4) The resident is evaluated periodically for continued need for the antidepressant medication .Antipsychotics: .2) Residents receive antipsychotic medication only for behaviors that are quantitatively and objectively documented through the use of behavioral monitoring charts or a similar mechanism. 3) Residents receive antipsychotic medication only for behaviors that are persistent, that are not caused by preventable reasons, and are causing the resident to: a) Present a danger to self or others. b) Continuously scream, yell, or pace. c) Experience psychotic symptoms (such as hallucinations, paranoia, delusions) .6) Residents who are receiving antipsychotic drug therapy are adequately monitored for significant side effects of such therapy .</p> <p>From 1/6/25 to 1/8/25, Surveyor reviewed R47's medical record. R47 was admitted to the facility on [DATE] with diagnoses including non-traumatic brain dysfunction (anoxic brain injury), insomnia, bipolar disorder, and severe unspecified dementia with agitation. R47's Minimum Data Set (MDS) assessment, dated 10/23/24, indicated R47 was rarely/never understood. R47 had a Guardian.</p> <p>R47's medical record contained the following psychotropic medication orders:</p> <p>~ diazepam 5 milligram (mg) tablet three times daily (TID) for anxiety/bipolar disorder</p> <p>~ quetiapine fumarate 300 mg every morning for bipolar disorder</p> <p>~ quetiapine fumarate 200 mg two times daily (BID) for bipolar disorder</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Brewster Village		STREET ADDRESS, CITY, STATE, ZIP CODE  3300 W Brewster St Appleton, WI 54914	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ mirtazapine 30 mg at bedtime (HS) for major depressive disorder</p> <p>R47's medical record did not contain monitoring interventions for adverse reactions to the psychotropic medications.</p> <p>On 1/8/25 at 11:13 AM, Surveyor interviewed Registered Nurse (RN)-L regarding psychotropic side effect/adverse reaction monitoring for R47. RN-L reviewed R47's medical record and indicated RN-L could not find any monitoring interventions for R47's psychotropic medications. RN-L and Surveyor reviewed R47's Medication Administration Record (MAR) and care plan which did not contain side effect/adverse reaction monitoring interventions.</p> <p>On 1/8/25 at 11:26 AM, Surveyor interviewed Director of Nursing (DON)-B who verified there were no adverse reaction psychotropic medication monitoring interventions in R47's medical record.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32768</p> <p>Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 2 residents (R) (R78 and R22) of 5 sampled residents observed during the provision of care. In addition, the facility did not have the appropriate transmission-based precautions in place for 1 (R214) of 3 sampled residents.</p> <p>Certified Nursing Assistant (CNA)-C did not appropriately cleanse hands or change gloves during incontinence care for R78.</p> <p>R22 was on enhanced barrier precautions (EBP). CNA-M and CNA-N did not don the appropriate personal protective equipment (PPE) during care for R22.</p> <p>R214 had a diagnosis of pneumonia and was symptomatic. R214 was not on droplet precautions.</p> <p>Findings include:</p> <p>The Facility's Hand/Hygiene Policy, dated 4/24, indicates: Hand hygiene is considered the single most important approach for preventing the spread of infection .Guidelines: 1. Cleanse your hands either with soap and water or alcohol-based hand gel: Before and after villager contact; Before and after any contact with villager environment, belongings, or equipment; Before and after wearing gloves; After moving from a dirty to clean area (i.e., moving between body sites, after touching any unsanitized area on a surface before touching anything else); During cares.</p> <p>The Facility's Enhanced Barrier Precautions Policy, dated 8/22, indicates: 1. EBP is an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high-contact resident care activity .EBP is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high-contact activity, such as part of morning or evening care. This extended contact with the resident and their environment increases the risk of MDROs spreading to staffs' hands and clothes .5. EBP is indicated .for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.</p> <p>The facility's Infection Surveillance policy, revised 8/2024, indicates: .1. When a resident exhibits signs/symptoms of a suspected infection .RN: .Review and ensure all policies and procedures are followed specific to presenting symptoms. C. Infection/Preventionist/Nursing Supervisor: .Monitor documentation until symptoms resolve and ensure interventions are initiated and appropriate.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Centers for Disease Control (CDC) at CDC.gov indicates: Transmission based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use droplet precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking.</p> <p>1. From 1/6/25 to 1/8/25, Surveyor reviewed R78's medical record. R78 was admitted to facility on 12/28/23 and had diagnoses including Parkinson's disease, dementia, urinary retention, overactive bladder, obstructive uropathy, benign prostatic hyperplasia (BPH), and urogenital implants. R78's Minimum Data Set (MDS) assessment, dated 12/26/24, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R78 was severely cognitively impaired. The MDS also indicated R78 was dependent on staff for transfers, hygiene, toileting and dressing.</p> <p>R78 had a history of urinary tract infections (UTIs) on 8/20/24 and 10/12/24.</p> <p>On 1/8/25 at 9:24 AM, Surveyor observed CNA-C and CNA-D provide catheter care for R78. CNA-C and CNA-D washed hands and donned gloves. CNA-C washed R78's face, hands, and under arms with a wash cloth. CNA-C and CNA-D then unfastened R78's soiled brief. CNA-C cleansed R78's Foley catheter tubing from the suprapubic site downward and dried the tubing with a towel. CNA-C and CNA-D then rolled R78 on the left side and CNA-C removed R78's soiled brief. With the same soiled gloves, CNA-C cleansed R78's buttocks from front to back two times. With the same soiled gloves, CNA-C applied barrier cream to R78's buttocks. CNA-C then removed the right glove and donned a clean glove without washing or sanitizing CNA-C's right hand. CNA-C and CNA-D then put a clean brief underneath R78. CNA-C touched the clean brief, R78, and R78's sheets. With the same soiled gloves, CNA-C fastened R78's brief and put a clean shirt on R78. CNA-C then bagged the soiled linens and brief, removed gloves, and washed hands.</p> <p>On 1/8/25 at 9:42 AM, Surveyor interviewed CNA-C who verified CNA-C did not appropriately change gloves or cleanse hands during the provision of care for R78.</p> <p>45943</p> <p>2. From 1/6/25 to 1/8/25, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis (MS), anxiety, and obstructive and reflux uropathy. R22's MDS assessment, dated 11/13/24, indicated R22 was not cognitively impaired. R22 was R22's own decision maker.</p> <p>R22 had a urostomy due to incontinence and was on EBP.</p> <p>On 1/7/25 at 1:41 PM, Surveyor observed an EBP sign on R22's door and observed CNA-M empty R22's urostomy bag while wearing a gown, gloves, and a mask. CNA-M then removed CMA-M's gown and gloves and called for assistance.</p> <p>On 1/7/25 at 1:51 PM, Surveyor observed CNA-M and CNA-N reposition R22 with pillows. CNA-M and CNA-N wore masks, but did not wear gowns and gloves when repositioning R22. CNA-M and CNA-N touched R22, R22's bed linens, and R22's pillows.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/7/25 at 1:57 PM, Surveyor interviewed CNA-M and CNA-N who verified CNA-M and CNA-N should have worn gowns and gloves while providing care for R22. CNA-M indicated EBP should be used when providing care to residents who have catheters, wounds, tube feedings, and ostomies.</p> <p>On 1/8/25 at 11:52 AM, Surveyor interviewed Director of Nursing (DON)-B who verified EBP should be used during high-contact care when a resident has an indwelling device, chronic wound, or history of an MDRO. DON-B verified repositioning a resident is considered high-contact care. DON-B also indicated DON-B expects staff to complete hand hygiene after removing soiled gloves before donning clean gloves. DON-B indicated R22 did not have an MDRO but verified R22 had a wound and a urostomy.</p> <p>43361</p> <p>3. From 1/6/25 to 1/8/25, Surveyor reviewed R214's medical record. R214 was admitted to the facility on [DATE] and had diagnoses including pneumonia and muscle weakness. R214's MDS assessment, dated 12/3/24, had a BIMS score of 11 out of 15 which indicated R214 had moderate cognitive impairment.</p> <p>On 1/6/25 at 10:03 AM, Surveyor observed R214 in R214's room and noted a contact precautions sign on R214's door.</p> <p>A progress note, dated 1/3/25 at 5:25 PM, indicated new orders were received to start IM (intramuscular) Rocephin 1 gram with lidocaine for 5 days.</p> <p>A progress note, dated 1/4/25 at 9:53 PM, indicated R214 had a respiratory condition with fatigue and an occasional cough.</p> <p>A progress note, dated 1/5/25 at 2:59 PM, indicated R214 had an ongoing change in condition, including poor appetite and poor oral intake. R214 took sips but refused all AM meds due to nausea and spitting up mucus.</p> <p>A progress note, dated 1/6/25 at 3:33 PM, indicated R214 had pneumonia, respiratory fatigue, and a productive cough with green/yellow phlegm. R214's lungs were diminished bilaterally with even respirations. R214 had an unlabored frequent cough.</p> <p>On 1/7/25, Surveyor noted R214 was no longer on precautions and there was no precautions sign or PPE cart outside R214's room.</p> <p>On 1/8/25 at 11:41 AM, Surveyor interviewed Registered Nurse (RN)-H who verified R214 was on precautions on 1/6/25 but was taken off because R214 had pneumonia. RN-H indicated R214 exhibited symptoms and was placed on contact precautions during testing. When Surveyor indicated R214's progress notes indicated R214 was coughing up phlegm, RN-H verified that was correct. RN-H indicated R214 was not leaving R214's room and was started on Hospice that morning. RN-H also indicated staff were wearing masks throughout the facility.</p> <p>On 1/8/25 at 12:40 PM, Surveyor interviewed DON-B. When Surveyor indicated R214's progress notes indicated R214 coughed up yellow and green phlegm on 1/6/25 and was currently on an antibiotic for pneumonia, DON-B indicated if R214 was still coughing up sputum, R214 should be on droplet precautions. DON-B also confirmed staff should change their masks upon exiting R214's room.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50988</p> <p>Based on staff interview and record review, the facility did not ensure vaccines were offered for 2 residents (R) (R80 and R36) of 5 sampled residents.</p> <p>R80 and R36 were not offered Prevnar 20 (PCV20) vaccines.</p> <p>Findings include:</p> <p>Abbreviations (www.cdc.gov):</p> <p>PCV13: 13-valent pneumococcal conjugate vaccine (Prevnar13(R))</p> <p>PCV20: 20-valent pneumococcal conjugate vaccine (Prevnar 20(R))</p> <p>PPSV23: 23-valent pneumococcal polysaccharide vaccine (Pneumovax23(R))</p> <p>The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete.</p> <p>The facility's Pneumococcal Vaccine policy, revised 5/2024, indicates: All villagers [AGE] years of age or older should be offered the pneumococcal vaccine unless medically contraindicated. For adults [AGE] years and older who have not previously received any pneumococcal vaccine, the CDC recommends you give 1 dose of PCV20. If PCV20 is used, their pneumococcal vaccinations are complete. For adults [AGE] years or older who have only received a PPSV23, the CDC recommends you give 1 dose of PCV20. The PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Their pneumococcal vaccinations are now complete. For adults [AGE] years and older who have only received PCV13, the CDC recommends you give 1 dose of PCV20. The PCV20 dose should be administered at least one year after the most recent PPSV13 as previously recommended. Their pneumococcal vaccinations are now complete. For Adults [AGE] years or older who have received the PVC20, their pneumococcal vaccinations are complete.</p> <p>1. From 1/6/25 to 1/8/25, Surveyor reviewed R80's medical record. R80 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia. R80's Minimum Data Set (MDS) assessment, dated 10/22/24, indicated R80 had severely impaired cognition. R80 had an activated Power of Attorney (POA).</p> <p>R80's medical record indicated R80 declined the PCV13 and PPSV23 vaccines on dated 6/11/21. R80's medical record did not indicate R80 was offered or received the PCV20 vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. From 1/6/25 to 1/8/25, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia. R36's MDS assessment, dated 12/27/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R36 had moderately impaired cognition. R36 had an activated POA.</p> <p>R36's medical record indicated R36 received the PCV13 vaccine on 6/20/16 and the PPSV23 vaccine on 3/5/08 (at [AGE] years of age). R36's medical record did not indicate R36 was offered or received the PCV20 vaccine.</p> <p>On 1/8/25 at 1:15 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R80 and R36 were not offered the PCV20 vaccine. According to the CDC guidelines, DON-B verified the PCV20 vaccine should have been offered to R80 and R36.</p>		