STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525108	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resolve at West Allis Respiratory and Rehab	9047 W Greenfield Ave West Allis, WI 53214

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, observation, and policy review, the facility failed to determine one of five sampled residents (Resident (R) 5) was safe in the self-administration of physician ordered medications. This failure had the potential for R5 not to take his medication and experience adverse effects of not taking the physician ordered medications.Findings include:Review of R5's undated Face Sheet located under the Profile' tab in the electronic medical record (EMR) indicated R5 was originally admitted to the facility on [DATE] with the diagnosis which included type two diabetes mellitus, hypertension, and transient ischemic attack.Review of R5's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 07/23/25 indicated R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 was cognitively intact.Review of R5's Physician Orders located under the Orders tab in the EMR indicated the following orders:-08/29/25 Amlodipine 10 mg (milligrams) Give one tablet by mouth on time a day. Hold for SBP (systolic blood pressure) < (less then) 100.-08/29/25 Aspirin 81 mg (Chewable) Give one tablet by mouth in the morning.-08/29/25 Atropine Solution 1% (percent) Instill one drop in left eye one time a day.-08/29/25 Hydrochlorothiazide 50 mg Give one tablet by mouth in the morning. Hold for SBP < 100.-04/23/25 Lantus Insulin 100 unit/ml (unit per milliliter) Inject six units subcutaneously in the morning-08/29/25 Lisinopril 40 mg Give one tablet by mouth in the morning. Hold for SBP < 100.-08/28/25 Carvedilol 6.25 mg Give one tablet by mouth in the morning and at bedtime. Hold for SBP < 100 or HR (heart rate) < 60.-08/28/25 Prednisolone Instill one drop in both eyes every morning and at bedtime.-08/28/25 Sodium Bicarbonate 650 mg Give two tablets by mouth three times a day.During an observation on 10/15/25 at 10:00 AM, Licensed Practical Nurse (LPN)1 took R5's morning medications into the resident's room and laid the medicine cup which contained the medications on the resident's overbed table. LPN1 exited the room and walked down the hallway to the next medication cart and then returned to R5's room and administered the medications to R5.During an interview on 10/15/25 at 10:20 AM, LPN1 was asked if R5 has been approved for to self-administer medications. LPN1 stated, I really don't know. LPN1 was then asked if she could view the medications when she left R5's room. LPN1 confirmed that she could not. LPN1 stated, I should have taken the medications with me when I left the room.During an interview on 10/15/25 at 4:52 PM, the Director of Nursing (DON) stated, If a nurse needs to leave the room, the nurse should have taken the medication with her and not leave the medications in the room with the resident. The DON confirmed R5 had not been approved for self-administration of medications.Review of the undated facility's policy Resident Self-Administration of Medication indicated, . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.Review of the undated facility's policy Medication Administration indicated, .Observe resident consumption of medication.

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure medication administration was timely for two of three residents (Resident (R)1 and R5) reviewed for late medications out of five sampled residents. This failure had the potential to interfere with the medication effectiveness.Findings include:1. Review of R1's updated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] with the diagnosis of quadriplegia, and pressure ulcer to left buttock.Review of R1's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 08/13/25 indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact. R1 was also coded as having a stage three pressure ulcer that was unhealed.During an interview on 10/13/25 at 2:55 PM, R1 stated he either received his medications too early or late. R1 reported the medications were Tylenol, Gabapentin, Baclofen, and Tizandine. R1 reported these medications are ones that he receives four times a day and if they are late in being administered to him affects the next doses that he receives would be too close together.Review of the August Medication Admin Audit Report, provided by the facility, revealed:On 08/03/25: scheduled for 8:00 AM and documented as being administered on 08/03/25 at 9:50 AM. Gabapentin 800 mg [milligrams] Give 1 tablet orally four times a day for pain. The administration was 50 minutes late.On 08/03/25: scheduled for 11:00 AM and documented as being administered on 08/03/25 at 1:42 PM. Tylenol Tablet 500 mg Give 2 tablets by mouth four times a day for pain. The administration was one hour and 42 minutes late.On 08/03/25: scheduled for 11:00 AM and documented as being administered at 1:43 PM. Tizanidine Tablet 2 mg Give 3 tablets by mouth four times a day for muscle spasm. and Baclofen Tablet 20 mg Give 1 by mouth four times a day for muscle spasm. The administration was one hour and 43 minutes late.On 08/03/25: scheduled for 12:00 PM and documented as being administered at 1:43 PM. Gabapentin Tablet 800 mg Give 1 tablet orally four times a day for pain. The administration was 43 minutes late.On 08/05/25: scheduled for 4:00 PM and documented as being administered at 6:00 PM. Gabapentin Tablet 800 mg Give 1 tablet orally four times a day for pain. The administration was one hour late.On 08/07/25: scheduled for 8:00 AM and documented as being administered at 9:42 AM. Gabapentin Tablet 800 mg Give 1 tablet orally four times a day for pain. The administration was 42 minutes late.On 08/07/25: scheduled for 11:00 AM and documented as being administered at 1:08 PM. Tylenol Tablet 500 mg Give 1 tablet by mouth four times a day for pain. The administration was one hour and eight minutes late.On 08/07/25: scheduled for 11:00 AM and documented as being administered at 1:07 PM. Baclofen Tablet 20 mg Give 1 tablet by mouth four times a day for muscle spasm. and Tizanidine Tablet 2 mg Give 3 tablets by mouth four times a day for muscle spasms. The administration was one hour and seven minutes late.On 08/13/25: scheduled for 11:00 PM and was documented as being administered at 3:08 AM on 08/14/25. Tylenol Tablet 500 mg -Give 2 tablets by mouth four times a day for pain, Tizanidine Tablet 2 mg- Give 3 tablet by mouth four times a day for muscle spasm. and Baclofen Tablet 20 mg- Give 1 tablet by mouth four times a day for muscle spasm. The administration was three hours and eight minutes late.On 08/15/25: scheduled for 11:00 PM and was documented as being administered at 3:16 AM on 08/16/25. Tylenol Tablet 500 mg-Give 2 tablets by mouth four times a day for pain, Tizanidine Tablet 2 m- Give 3 tablet by mouth four times a day for muscle spasm, and Baclofen Tablet 20 mg- Give 1 tablet by mouth four times a day for muscle spasm. The administration was three hours and sixteen minutes late.On 08/25/25: scheduled for 8:00 PM and documented as being administered at 10:35 PM. Gabapentin Tablet 800 mg Give 1 tablet orally four times a day for pain. The administration was an hour and 35 minutes late.On 08/26/25: scheduled for 20:00 (8:00 PM) and documented as being administered at 22:26 (10:26 PM). Gabapentin Tablet 800 mg-Give 1 tablet orally four times a day for pain. The administration was an hour and 26 minutes late.On 10/02/25: scheduled for 11:00 AM and documented as being given at 1:12 PM. 11:00 AM and documented as being administered at 1:07 PM. Baclofen Tablet 20 mg-Give 1 tablet by mouth four times a day for muscle spasm, and Tizanidine Tablet 2 mg-Give 3 tablets by mouth four times a day for muscle spasms, and Tylenol Tablet 500 mg-Give 1 tablet by mouth four times a day for pain. The administration was one hour and twelve minutes late.On 10/06/25: scheduled for 11:00 AM and documented as being given at 1:47 PM. Baclofen Tablet 20 mg-Give 1 tablet by mouth four times a day for muscle spasm, Tizanidine Tablet 2 mg- Give 3 tablets by mouth four times a day for muscle spasms, and Tylenol Tablet 500 mg-Give 1 tablet by mouth four times a day for pain. The

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and document review, the facility failed 1. to prime an unused insulin pen prior to the injection of insulin as well as 2. failed to ensure the insulin was administered as ordered for one of five sampled residents (Resident (R)5). This failure had the potential for R5 not to receive the physician ordered amount of insulin to R5 and the potential to have uncontrolled blood sugars as a result of this action.Findings include:Review of R5's Review of R5's undated Face Sheet located under the Profile' tab in the electronic medical record (EMR) indicated R5 was originally admitted to the facility on [DATE] with the diagnosis which included type two diabetes mellitus, hypertension, and transient ischemic attack.Review of R5's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 07/23/25 indicated R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 was cognitively intact.Review of R5's Physician Orders located under the Orders tab in the EMR indicated an order dated 04/23/25 for Lantus Solostar Subcutaneous Solution Pen-Injector 100 unit/ml [unit per milliliter] (Insulin Glargine) Inject six unit subcutaneously in the morning for (DM2) [diabetes mellitus type two].1. During an observation on 10/15/25 at 10:00 AM, Licensed Practical Nurse (LPN)1 was observed opening a new insulin pen and connecting a needle to the injector pen. LPN1 proceeded to take the Lantus insulin pen into R5's room and administered six units of the insulin to R5. LPN1 was asked if she primed the insulin pen prior to administering the insulin to R5. LPN1 stated, No, I didn't but I should have.During an interview on 10/15/25 at 11:30 AM, the Director of Nursing (DON) stated, You always have to prime the injector pen of insulin each time prior to the administration of insulin. That way you know the resident will receive the proper amount of insulin that was ordered by the physician.Review of the undated facility's policy Insulin Pen indicated, .Insulin pens will be primed prior to the use to avoid collection of air in the insulin reservoir. Prime the insulin pen.Dial 2 [sic] units by turning the dose selector clockwise. With the needle pointing down, push the plunger, and watch to see at least one drop of insulin appears [sic] on the tip of the needle. If not, repeat until at least one drop appears.2. Review of the Medication Admin Audit Report provided by the facility indicated:On 10/01/25: scheduled for 8:00 AM and was documented as being administered at 12:22 PM. Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML [unit per milliliter] (Insulin Glargine) Inject 6 unit subcutaneously in the morning for DM2 [diabetes mellitus, type two]. The administration was three hours and 22 minutes late.On 10/07/25: scheduled for 8:00 AM and was documented as being administered at 1:47 PM. Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 6 unit subcutaneously in the morning for DM2. The administration was four hours and 47 minutes late.On 10/08/25: scheduled for 8:00 AM and was documented as being administered at 12:31 PM. Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 6 unit subcutaneously in the morning for DM2. The administration was three hours and 31 minutes late.On 10/10/25: scheduled for 8:00 AM and was documented as being administered at 12:14 PM. Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 6 unit subcutaneously in the morning for DM2. The administration was three hours and 14 minutes late.On 10/12/25: scheduled for 8:00 AM and was documented as being administered at 2:09 PM. Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 6 unit subcutaneously in the morning for DM2. The administration was five hours and nine minutes late.During an interview on 10/14/25 at 1:44 PM, Licensed Practical Nurse (LPN)2 stated, We have an hour and an hour after the scheduled time before it is considered being given late to the resident.During an interview on 10/15/25 at 4:52 PM, the Director of Nursing (DON) stated, the nurses are taught they have an hour before and an hour after that the medication is considered being given late to the residents. The staff received education on this began in August, with the latest education provided was on 10/06/25 and 10/07/25.Review of the Journal and Family Medicine and Primary Care article titled, Errors in diabetic insulin therapy and the vitality of proper precautions in Bangladesh: Real-life insights from the developing world indicated, .Insulin is considered a high-alert medication (HAM), which means that mistakes with this medication, either in preparation or administration, can have very serious consequences .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and document review, the facility failed to follow infection control guidelines during a wound care observation for two of three residents (Resident (R)1 and R4) observed out of five sampled residents. This failure had the potential for R1 and R4 to be exposed to infections.Findings include:1.Review of R1's updated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R1 was admitted to the facility on [DATE] with the diagnosis of quadriplegia, and pressure ulcer to left buttock.Review of R1's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 08/13/25 indicated R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact. R1 was also coded as having a stage three pressure ulcer that was unhealed.Review of R1's Physician Orders located under the Orders tab in the EMR indicated an order dated 10/06/25 for Left buttock PI [pressure injury] Cleanse with 1/2 [half] strength dankins [sic] f/b [followed by] pat dry f/b calcium alginate AG [silver] f/b bordered foam dressing every day [sic] shift for wound care and as needed for soiled or misplaced dressing.During a wound care observation on 10/15/25 at 6:35 AM, the Wound Care Nurse (WCN) placed a barrier on the overbed table and then placed the unopened wound care supplies on it. WCN then proceeded to don a pair of clean gloves on and helped the Certified Nursing Assistant (CNA) to reposition R1 in bed. The WCN did not remove the dirty gloves and sanitize her hands and apply a clean pair of gloves on prior to removing the old dressing. The WCN did not remove the dirty gloves, sanitize her hands and apply a new pair of clean gloves prior to opening the 4x4 package and then cleaned the wound with Dankins Solution. WCN removed her gloves, sanitized her hands then don another pair of clean gloves on. The WCN then opened the package of clean 4x4's and patted R1's wound dry with the 4x4. The WCN removed the dirty gloves and donned clean gloves but did not sanitize her hands between glove changes. WCN opened the calcium alginate AG package and removed the clean dressing supply then applied this to R1's wound. The WCN then applied the bordered dressing to R1's wound.2.Review of R4's undated Face Sheet located under the Profile tab in the EMR indicated R4 was admitted to the facility on [DATE] with the diagnosis of respiratory failure and anoxic brain injury.Review of R4's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 08/22/25 indicated R4 was coded as having short- and long-term memory problems and being severely impaired in making daily decisions. R4 was also coded as having an unhealed stage three pressure ulcer.Review of R4's Care Plan located under the Care Plan tab in the EMR indicated R4 had a Focus dated 05/16/25 for Actual Skin Impairment [sic] and high risk for further impairment r/t [related to] Pressure Ulcers [sic], limited mobility, incontinence, altered nutrition [sic]. Interventions included, .Measure wounds at least weekly. Inform MD [medical doctor] if area is worsening. Treatment as ordered.Review of R4's Physician Orders located under the Orders tab in the EMR indicated an order dated 09/15/25 for Sacrum PI [pressure injury]: cleanse [sic] wound with normal saline f/b [followed by] pat dry f/b xeroform [sic] f/b bordered gauze dressing every day [sic] shift for wound care and as needed for soiled or misplaced dressing.During an observation on 10/15/25 at 7:10 AM, the WCN applied a clean barrier down on the overbed table and placed the unopened wound care supplies and scissors on the barrier. WCN then proceeded to don a pair of clean gloves on and helped the Certified Nursing Assistant (CNA) to reposition R4 in bed. The WCN removed the old dressing, opened the 4x4 package and cleaned the wound with Normal Saline. WCN removed her gloves, sanitized her hands then don another pair of clean gloves on. The WCN then opened the package of clean 4x4's and patted R4's wound dry with the 4x4. The WCN removed the dirty gloves and donned clean gloves but did not sanitize her hands. WCN opened the Xeroform package, cut the Xeroform and place this in the wound bed. The WCN did not sanitize the scissors prior to use of cutting the Xeroform dressing. The WCN the opened the bordered dressing package, removed it, and applied it to R4's wound.During an interview on 10/15/25 at 8:15 AM, the WCN was asked what should be done after she removes the dirty gloves and before she dons the clean gloves. The WCN stated, I should sanitize my hands. The WCN was then asked what she had should have done to the overbed table prior to placing the clean barrier down on the overbed table. The WCN stated, I should have cleaned it with a disinfectant wipe, and I should have opened the dressing supply packages prior to performing the wound care.During an interview on 10/15/25 at 3:51 PM, the Infection Preventionist (IP) nurse stated, The nurse should have sanitized the overbed table prior to placing the barrier on the overbed table, should have