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	01/14/2026

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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 3 (R2, R3, and R4) of 3 residents and/or representative were notified of the reason for transfer/discharge in writing and the rate to reserve the residents' bed was not documented in the Bed Hold and Notice of Transfer. *R2 was discharged to the hospital on [DATE] and 12/28/25. The facility's transfer and discharge notice was not provided in writing and in a language understood to R2 and/or R2's representative. R2's bed hold notices did not document the facility per diem daily rate. *R3 was discharged to the hospital on [DATE], 12/2/25, 12/7/25 and 12/11/25. The facility's transfer and discharge notice was not provided in writing and in a language understood to R3 and/or R3's representative. R3's bed hold notices did not document the facility per diem daily rate. *R4 was discharged to the hospital on [DATE]. The facility's transfer and discharge notice was not provided in writing and in a language understood to R4 and/or R4's representative. R4's bed hold notices did not document the facility per diem daily rate. Findings include: The facility's policy titled, Bed Hold Notice and reviewed/revised 8/2025 documents: Policy: . It is the policy of this facility to provide written information to the resident and/or representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. Policy Explanation and Compliance Guidelines: . 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifics: a. The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. b. The reserve bed payment policy in the state plan policy, if any. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility: The resident requires the services which the facility provides; The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. 4. The facility will provide this written information to all facility residents, regardless of their payment source. 1.) R2 was admitted to the facility on [DATE] with diagnoses of Quadriplegia (partial or complete loss of function in all four limbs), Epilepsy (disorder in which nerve cell activity in brain is disturbed causing seizures), Dysphagia (difficulty swallowing foods), Insomnia (sleep disorder characterized by difficulty falling asleep), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R2 was discharged to the hospital on [DATE] and has not returned to the facility. R2's Quarterly Minimum Data Set (MDS) completed 11/5/25 documents R2's Brief Interview for Mental Status (BIMS) score to be 15, indicating R2 is cognitively intact for daily decision making. R2 was transferred to the hospital on [DATE]. The facility's Notice of Resident Transfer or Discharge documents: Dear [R2], the intent of this notice is to remind you of this facility's admission agreement. A resident may be transferred/discharged when the facility determines that this action is necessary. This is to meet the resident's needs should we not be able to. The facility has determined that a transfer/discharge is necessary on this date: 12-9-25. Reason(s) for transfer/discharge: The transfer is necessary for the resident's welfare and the resident's needs cannot be met by the facility. Specify: Sent out for NP (nasal prongs) The location to be transferred/discharged to is documented for R2. Surveyor notes the transfer notice documents the required agencies to contact for the appeal process. R2's transfer notice is signed by a facility employee but is not acknowledged by R2 or R2's (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative. R2's Bed Hold Notice documents: . This notice is presented to you because of the following: Select One: -admission to the hospital -Temporary therapeutic leave from the facility. Surveyor notes there is no above reason checked for R2's need for a bed hold. There are 2 different options to choose from on the facility bed hold notice: -Request for bed hold -Release of bed The facility bed hold notice documents: . I, [R2] a resident of this facility, hereby request that the facility hold a bed during my absence from the facility. I understand that by making this request I am responsible for payment of the basic per diem rate. Surveyor notes that the facility basic per diem rate is not filled out. R2's bed hold notice documents R2's POA agrees to bed hold. R2's electronic medical record (EMR) does not contain documentation that R2 and/or R2's representative was notified in writing in a language they understand and acknowledged R2's transfer deemed necessary along with appeal rights. R2 was transferred to the hospital again on 12/28/25. The facility's Notice of Resident Transfer or Discharge documents: Dear [R2], the intent of this notice is to remind you of this facility's admission agreement. A resident may be transferred/discharged when the facility determines that this action is necessary. This is to meet the resident's needs should we not be able to. The facility has determined that a transfer/discharge is necessary on this date: 12-28-25. Reason(s) for transfer/discharge: The transfer is necessary for the resident's welfare and the resident's needs cannot be met by the facility. Specify: Surveyor notes this is blank. The location to be transferred/discharged to is documented for R2. Surveyor notes the transfer notice documents the required agencies to contact for the appeal (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process. R2's transfer notice is signed by a facility employee but is not acknowledged by R2 or R2's representative as having received the transfer notice in writing. R2's Bed Hold Notice documents: . This notice is presented to you because of the following: Select One: -admission to the hospital -Temporary therapeutic leave from the facility. Surveyor notes admission to the hospital is checked. There are 2 different options to choose from on the facility bed hold notice: -Request for bed hold -Release of bed The facility bed hold notice documents: . I, representative of R2 request that the facility hold a bed during my absence from the facility. I understand that I will be responsible for payment of the basic per diem rate. Surveyor notes the facility basic per diem rate is not filled out. R2's bed hold notice documents that R2's representative was provided a verbal notice for the bed hold. R2's electronic medical record (EMR) does not contain documentation that R2 and/or R2's representative was notified in writing in a language they understand and acknowledged R2's transfer deemed necessary along with appeal rights. On 1/14/26, at 2:16 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regard to the facility's notice of resident transfer or discharge and bed hold notice. NHA-A verified the facility only gets verbal acknowledgement by a resident and/or representative of the bed hold notice and transfer or discharge notice. NHA-A states the facility per diem differs depending on basic, private, trach, or vent care. If there is a concern, NHA-A would clarify. Surveyor shared the concern with NHA-A that R2's transfer or discharge notice was not provided to R2 and/or representative in written form in a language understood. Surveyor shared the facility per diem rate to hold the bed after 15 days was blank on R2's 12/9 and 12/28/25 bed hold notices. NHA-A confirmed R2 would have the vent facility per diem rate. NHA-A understands the concerns. Surveyor requested the transfer or discharge notice policy. The facility has not provided the facility at this time. No further information has been provided by the facility at this time. 2). R3 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (a condition where the lungs cannot get enough oxygen in the blood leading to oxygen (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deprivation in tissues), tracheostomy status (a breathing tube placed into the neck), and cognitive communication deficit. R3's admission Minimum Data Set (MDS) dated [DATE] documents R3 has short-term and long-term memory problems, and R3 is rarely understood and rarely understands others. R3 has a guardian. R3 was hospitalized on [DATE] due to respiratory distress. R3 returned to the facility on [DATE]. Surveyor reviewed R3's electronic health record (EHR) and located a notice of transfer and bed hold notice document dated 10/31/25. Surveyor notes on the bottom of the notice of transfer document there is a blank line for the resident or resident representative to sign and date acknowledging receipt of the notice of transfer. Surveyor notes there is no signature of R3's guardian on the notice of transfer dated 10/31/25. Surveyor notes on the bed hold notice dated 10/31/25, Licensed Practical Nurse (LPN)-G, employed by the facility, consented to holding R3's bed, and there is no evidence that R3's guardian consented to holding R3's bed during this hospitalization on the bed hold notice document. Surveyor notes there is no daily rate documented on the bed hold form dated 10/31/25. R3 was hospitalized on [DATE] due to altered mental status. R3 returned to the facility on [DATE]. Surveyor reviewed R3's EHR and located a notice of transfer and bed hold notice document dated 12/2/25. Surveyor notes on the bottom of the notice of transfer document there is a blank line for the resident or resident representative to sign and date acknowledging receipt of the notice of transfer. Surveyor notes there is no signature of R3's guardian on the notice of transfer dated 12/2/25. Surveyor notes on the bed hold notice dated 12/2/25, Licensed Practical Nurse (LPN)-H, employed by the facility, consented to holding R3's bed, and there is no evidence that R3's guardian consented to holding R3's bed during this hospitalization on the bed hold notice document. Surveyor notes there is no daily rate documented on the bed hold form dated 12/2/25. R3 was hospitalized on [DATE] due to abnormal vitals. R3 returned to the facility on [DATE]. Surveyor reviewed R3's EHR and located a notice of transfer and bed hold notice document dated 12/7/25. Surveyor notes the bottom of the notice of transfer documents verbal consent was obtained from R3's guardian, however, there is no evidence that the notice of transfer was provided in writing to R3's guardian. Surveyor notes there is no daily rate documented on the bed hold form dated 12/7/25. R3 was hospitalized on [DATE] due to abnormal vitals and difficulty breathing. R3 returned to the facility on [DATE]. Surveyor reviewed R3's EHR and located a notice of transfer and bed hold notice document dated 12/11/25. Surveyor notes the bottom of the notice of transfer documents verbal consent was obtained from R3's guardian, however, there is no evidence that the notice of transfer was provided in writing to R3's guardian. Surveyor notes there is no daily rate documented on the bed hold form dated 12/11/25. In an interview on 1/14/26 at 8:55 AM with Nursing Home Administrator (NHA)-A, NHA-A stated the nurse on duty is responsible for obtaining and filling out the notice of transfer and bed hold notice when a resident goes to the hospital. NHA-A stated verbal consent is obtained from a resident representative if the resident is not their own person. NHA-A was not sure if the notice of transfer and bed hold notice is provided to the resident representative in writing but would further look into it. In an interview on 1/14/26 at 2:16 PM with NHA-A and Director of Nursing (DON)-B, NHA-A confirmed only verbal consent is obtained on the notice of transfer and bed hold notice and no copy is sent to a resident representative in writing. NHA-A confirmed consent to hold a resident's bed should be obtained from the resident or the resident's representative and not from a facility nurse. NHA-A stated the daily bed hold rate is listed in the admission paperwork that is signed by the resident or (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their representative on admission. Surveyor shared concern with NHA-A and DON-B that R3's notice of transfer on dates 10/31/25, 12/2/25, 12/7/25, and 12/11/25 does not document evidence that the notice of transfer was provided to R3's guardian in writing. Surveyor shared concern with NHA-A and DON-B that R3's bed hold notice on dates 10/31/25 and 12/2/25 documents LPN-G and LPN-H providing consent to hold R3's bed and there is no evidence of R3's guardian providing consent to holding R3's bed. Surveyor shared concern with NHA-A and DON-B that the daily bed hold rate is not specified on R3's bed hold notice on dates 10/31/25, 12/2/25, 12/7/25, or 12/11/25. No further information was provided. 3.) R4 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure (not enough oxygen or too much carbon dioxide in the body), dependence on respirator (ventilator) (dependence of a machine to breathe), encephalopathy (altered brain function due to toxin/trauma/infection), dysphagia (difficulty swallowing that is hazardous and can cause choking or inhalation of liquids), Tracheostomy status (a medical opening in the throat to provide another way of breathing), and Traumatic subdural hemorrhage (bleeding in the brain). R4 has a legal guardian. R4 was hospitalized on [DATE] due to Pneumonia, increased heart rate, fever, and increased secretions on the respiratory tract. R4 returned to the facility on [DATE]. Surveyor reviewed R4's electronic health record (EHR) and located a notice of transfer and bed hold notice document dated 10/29/25. Surveyor noted on the bed hold notice Licensed Practical Nurse (LPN)-O signed on the resident's representative signature line, consenting to holding R4's bed. Surveyor noted there is no daily rate documented on the bed hold form and R4's legal guardian did not sign the bed hold form. R4 was hospitalized on [DATE] due to respiratory distress. R4 returned to the facility on [DATE]. Surveyor reviewed R4's EHR and located a notice of transfer and bed hold notice document dated 12/2/25. Surveyor noted on the bottom of the notice of transfer document there is a blank line for the resident or resident representative to sign and date acknowledging receipt of the notice of transfer. Surveyor noted there is no signature of R4's guardian on the notice of transfer. Surveyor noted on the bed hold notice there is no evidence that R4's guardian consented to holding R4's bed on the bed hold notice document. Surveyor noted there is no daily rate documented on the bed hold form. On 1/14/26, at 8:55 AM, A Surveyor interviewed Nursing Home Administrator (NHA)-A, NHA-A stated the nurse on duty is responsible for obtaining and filling out the notice of transfer and bed hold notice when a resident goes to the hospital. NHA-A stated verbal consent is obtained from a resident representative if the resident is not their own person. NHA-A was not sure if the notice of transfer and bed hold notice is provided to the resident representative in writing but would further look into it. On 1/14/26, at 2:16 PM, A Surveyor interviewed NHA-A and Director of Nursing (DON)-B. NHA-A confirmed only verbal consent is obtained on the notice of transfer and bed hold notice and no copy is sent to a resident representative in writing. NHA-A confirmed consent to hold a resident's bed should be obtained from the resident or the resident's representative and not from a facility nurse. NHA-A stated the daily bed hold rate is listed in the admission paperwork that is signed by the resident or their representative on admission. Surveyor shared concern with NHA-A and DON-B that R4's notice of transfer on dates 12/2/25 and 11/3/25 does not document evidence that the notice of transfer was provided to R4's guardian in writing. Surveyor shared concern with NHA-A and DON-B that R4's bed hold notice on dates 10/29/25 documented LPN-O providing consent to hold R4's bed and there is no evidence of R4's guardian providing consent to holding R4's bed. Surveyor shared concern with NHA-A and DON-B that the daily bed hold rate is not specified on R4's bed hold notice on dates 10/29/25, and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/2/25. No further information was provided from the facility at this time.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the Facility did not ensure there was a medication error rate below 5 percent. There were 2 medication errors in 31 opportunities which resulted in a medication error rate of 6.45%. Medication errors were identified for R7 & R9.*R7's Prednisolone Acetate Ophthalmic Solution 1% was not shaken prior to administration.*R9 was administered two drops of Cromolyn Sodium 4% eye drops into each eye without waiting one minute between drops.Findings include:The facility's policy titled, Administration of Eye Drops or Ointments and not dated under Policy documents Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat certain eye conditions.1.) On 1/14/26, at 12:16 p.m., Surveyor observed Licensed Practical Nurse (LPN)-C remove a glucometer and a clear bag containing R7's Prednisolone Acetate Ophthalmic Solution 1% from the medication cart. Surveyor observed the clear bag containing this eye drop is affixed with a blue sticker instructing to shake well. On 1/14/26, at 12:17 p.m., Surveyor observed LPN-C enter R7's room with a glucometer and the bag containing R7's Prednisolone Acetate 1% eye drops. LPN-C informed R7 she was going to check R7's blood sugar and administer her eye drops. After checking R7's blood sugar, LPN-C removed her gloves, and cleansed her hands.On 1/14/26, at 12:20 p.m., Surveyor observed LPN-C place gloves on and hand R7 a Kleenex. LPN-C removed Prednisolone Acetate 1% eye drops from the bag, removed the eye drop bottle top, and administer 1 drop into R7's left eye. Surveyor did not observe LPN-C shake Prednisolone Acetate 1% eye drops. After administering R7's eye drop, LPN-C removed her gloves, went into the bathroom, and washed her hands. After administering R7's eye drops, LPN-C prepared and administered Humalog 10 units according to physician orders.On 1/14/26, at 1:03 p.m., Surveyor asked LPN-C why she didn't shake R7's Prednisolone Acetate 1% eye drops. LPN-C informed Surveyor she did, making the motion of tipping the bottle down and then upright. Surveyor informed LPN-C R7's Prednisolone Acetate 1% should be shaken well before administration not tipped over and back up.On 1/14/26, at 1:13 p.m., Surveyor asked Nurse Manager/Licensed Practical Nurse (NM/LPN)-E if there is a label on an eye drop container to shake well how should the nurse shake the eye drops. NM/LPN-E showed Surveyor by moving her hand back & forth quickly multiple times. Surveyor informed NM/LPN-E R7's Prednisolone Acetate 1% eye drops bag was affixed with a blue sticker instructing to shake well. Surveyor did not observe LPN-C shake R7's eye drops prior to administration. This observation resulted in a medication error for R7.2.) On 1/14/26, at 1:37 p.m., Surveyor observed Certified Medication Aide (CMA)-D cleanse her hands and start to prepare R9's medication which consisted of Acetaminophen 500 mg (milligrams) 2 tablets, Clonidine HCL 0.2 mg one tablet, Cromolyn Sodium Ophthalmic Solution 4 %, Oxycodone HCL 5 mg one tablet, and Tizanidine HCL 2 mg one tablet.On 1/14/26, at 1:41 p.m., Surveyor verified the number of pills in the medication cup with CMA-D. CMA-D then placed gloves and a gown on, entered R9's room and asked R9 if R9 was ready to take the medication.On 1/14/26, at 1:44 p.m., CMA-D administered R9's medication whole with water.On 1/14/26, at 1:45 p.m., CMA-D informed R9 she has his eye drops and handed R9 a Kleenex. CMA-D instilled two drops of Cromolyn Sodium 4% eye drops into R9's left eye, stating one, two while instilling the eye drops. CMA-D then administered two drops of Cromolyn Sodium 4% into R9's right eye, stating one, two while instilling the eye drops. CMA-D did not wait any time between R9's eye drops in either eye.This observation resulted in one medication error for R9.On 1/14/26, at 2:03 p.m., Surveyor asked Director of Nursing (DON)-B how long the nurse should wait between drops when administering eye drops to a resident. DON-B informed Surveyor one minute between drops of the same eye medication and three to five minutes between different eye medication. Surveyor informed DON-B Surveyor observed CMA-D administer two drops of Cromolyn Sodium 4% into R9's right & left eye without waiting one (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minute in between drops.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 1 (R7) of 1 resident were free of significant medication errors.R7 was admitted to the facility on [DATE]. R7's has an order for Acetaminophen 1000 mg (milligrams) by mouth every 6 hours for pain/discomfort with a start date of 8/21/25. This order was not entered correctly, and Acetaminophen 1000 mg did not appear on R7's monthly medication administration records resulting in R7 not receiving Acetaminophen 1000 mg every six hours daily. R7 missed 48 doses in August 2025, 120 doses in September 2025, 124 doses in October 2025, 120 doses in November 2025, 124 doses in December 2025, and 53 doses in January 2026. R7 was not administered 589 doses of Acetaminophen 1000 mg.Findings include:The facility's policy titled, Medication Orders and not dated under Policy Explanation and Compliance Guidelines documents for 4. Documentation of Medication Orders: a. Each medication order should be documented with the date, time and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR). f. Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR.R7 was admitted to the facility on [DATE] with diagnosis which include left periprosthetic distal femur fracture (a break in the thigh bone occurring near a hip replacement prosthesis).R7's physician orders include Acetaminophen Oral Tablet (Acetaminophen). Give 1000 mg (milligrams) by mouth every 6 hours for Pain/Discomfort. Do not exceed more than 4g (grams) of acetaminophen from any source with an order & start date of 8/21/25.Advanced Practice Nurse Prescriber (APNP)-I progress note dated 8/22/25 under subjective documents [R7's name], [AGE] year old female, is seen today for follow-up evaluation on day 2 of her SNF (skilled nursing facility) stay. She was admitted yesterday following hospitalization for a left periprosthetic distal femur fracture that was treated with retrograde intramedullary nail fixation on 8/14/2025. Patient is seen sitting up in bed, awake and alert. She reports pain is overall controlled. Appetite and sleep are stable. She continues on Tylenol, oxycodone, and Zanaflex for pain management.R7's Orthopaedic Clinic after visit summary dated 11/26/25 under continue taking these medications documents acetaminophen 500 mg tablet Commonly known as: Tylenol. Take 2 tablets (1,000 mg total) by mouth every 6 hours. This was noted by Licensed Practical Nurse (LPN)-C on 11/26/25.On 1/14/26, at 11:02 a.m., Surveyor reviewed R7's August 2025 MAR (Medication Administration Record), September 2025 MAR, October 2025 MAR, November 2025 MAR, December 2025 MAR, and January 2026 MAR. Surveyor noted R7's order for Acetaminophen Oral Tablet (Acetaminophen). Give 1000 mg by mouth every 6 hours for Pain/Discomfort. Do not exceed more than 4 grams in not listed on any of R7's MARs.On 1/14/26, at 11:24 a.m., Surveyor asked LPN-C if she is going to administer any medications to R7 this afternoon. LPN-C informed Surveyor R7 gets a blood sugar and eye drops usually after 12:00 p.m. On 1/14/26, from 12:20 p.m. to 12:24 p.m., Surveyor observed LPN-C administer R7's medication which consisted of Prednisolone Acetate Ophthalmic Suspension 1% and Humalog 10 units. At 12:25 p.m., Surveyor asked LPN-C if this is all of R7's medications to be administered. LPN-C replied yes doesn't get anything else.On 1/14/26, at 12:44 p.m. Surveyor asked Nurse Manager/Licensed Practical Nurse (NM/LPN)-E if she could explain the facility's process regarding medication for a new admission. NM/LPN-E informed Surveyor when a resident is admitted they receive an admission packet from the hospital. NM/LPN-E explained they put the orders in off the hospital AVS (after visit summary). NM/LPN-E informed Surveyor they do three checks explaining if she puts the order in, the supervisor on the next shift and one of the nurses will review the orders. Surveyor asked NM/LPN-E if the physician orders under the order tab are the resident's current orders. NM/LPN-E replied yes. Surveyor asked NM/LPN-E if she could pull up R7's orders on her computer screen. (continued on next page)

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	525108	A. Building B. Wing	01/14/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked NM/LPN-E if she sees an order for Acetaminophen 1000 mg every six hours. NM/LPN-E replied yes. Surveyor informed NM/LPN-E R7's Acetaminophen 1000 mg every six hours is not listed on any MAR and R7 has not received this medication since admission. NM/LPN-E reviewed R7's order in the computer and informed Surveyor she sees why the nurses aren't seeing the medication. NM/LPN-E explain when the order was initially entered the order type was entered as pharmacy and it's supposed to say standard medication MAR. NM/LPN-E informed Surveyor it's not popping up for the nurses. NM/LPN-E informed Surveyor she can't answer how the order was put in because she wasn't employed at the facility at the time. NM/LPN-E informed Surveyor she just fixed it and is going to tell LPN-C to give R7 the Acetaminophen. On 1/14/26, at 2:06 p.m., Surveyor asked Director of Nursing (DON)-B how the facility ensures resident's medication are entered correctly so the resident receives their medication as ordered by the physician. DON-B explained they have a three-person check. DON-B informed Surveyor they also have [name of pharmacy company] who checks remotely and will send pharmacy recommendations. Surveyor informed DON-B R7 has not received Acetaminophen 1000 mg every six hours according to physician orders since admission as the order type was incorrectly entered as pharmacy and did not appear on any MAR. Surveyor asked DON-B if she has received a pharmacy recommendation for R7. DON-B replied no not for Tylenol.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 1 (R11) of 3 residents reviewed for medication administration via Enteral Tube (ET) (a tube that is connected to the digestive system and is used to deliver hydration, nutrition, or medications.) R11 was on Enhanced Barrier Precautions (EBP), a staff member placed a graduated cylinder and syringe, from R11's room that's used for R11's ET cares, on the nurse's medication cart leaving residual fluid on the cart. The staff member did not sanitize the cart but then began preparing the next medication administration for another resident by placing cups on the contaminated cart/fluid. R11 is on EBP, a staff member did not maintain EBP after providing cares to R11. The staff member did not remove Personal Protective Equipment (PPE) before grabbing a spoon from the shared container off of the nurse's medication cart (that all residents use) with contaminated gloves. A staff member wiped off a syringe with a contaminated glove multiple times that would be used to deliver and remove fluid from R11's digestive tract. Findings Include: The facility policy, titled Medication Administration, with no date, review date, and revision date; states in part:Keep medication cart clean. The facility policy, titled Enhanced Barrier Precautions, with no date, review date, and revision date; states in part: Enhanced Barrier precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves to use during high contact resident care activities.In order for enhanced barrier precautions will be obtained for residents with any of the following:. And/or indwelling medical devices (e.g., .urinary catheters, Feeding tubes, tracheostomy/ ventilator tubes.). PPE for EBP is only necessary when performing high contact care activities.Position the trash can inside of the resident room and near the exit for discarding PPE after removal, prior to the exit of the room or before providing care for another resident in the same room.High contact resident care activities include:device care or use: urinary catheter, feeding tubes, tracheostomy/ ventilator tubes. R11 was admitted to the facility on [DATE] with diagnoses of Acute respiratory failure with hypoxia (the lungs cannot get enough oxygen to the blood requiring oxygenation through a ventilation system), tracheostomy status (a medical opening in the neck that has a tube placed to assist with breathing), and gastronomy status (a tube inserted into the stomach).R11's Quarterly Minimum Data Set (MDS) dated [DATE] documented R11 is rarely or never understood, has short, long term memory impairment, and severely impaired skills for daily decision making. R11 has range of motion impairment of both sides of the body and upper and lower body. R11 is dependent on staff for hygiene, showers, bed mobility, and transferring. R11's Kardex as of 1/14/26, (which indicates to staff how to care for R11) documents:Resident is NPO (nothing by mouth) and requires continuous tube feedingcatheter: the resident has (specify size 16 French 10CC.)Perform trach care is ordered R11's Care Plan as of 1/14/26 documented:The resident has a tracheostomy R/T (related to) impaired breathing mechanics. Date initiated: 7/23/25use universal precautions as appropriate. Date initiated 7/23/25The resident has indwelling catheter: neurogenic bladder data initiated 7/23/25, revision on 7/30/25 On 1/14/26, at 12:05 PM, Surveyor observed Licensed practical Nurse (LPN)- J administer R11's medications through R11's ET. On the outside of R11's door is a sign indicating EBP and staff must perform hand hygiene and wear a gown and gloves to perform cares. All other visitors must perform hand hygiene. LPN-J was outside of R11's room, preformed hand hygiene applied a gown and gloves and recorded R11's vital signs. LPN-J removed gloves and gown, then preformed hand hygiene. LPN-J verified R11's medication that were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due, crushed the medication, and placed the medication in a cup. LPN-J preformed hand hygiene, walked into R11's room, grabbed (without gloves) R11's graduated cylinder and syringe that is prefilled with water (this is used to push fluids, medications, and remove residual stomach fluids for R11) and placed the graduated cylinder on the medication cart. The graduated cylinder left a puddle of water with unknown contaminates on the nurse's cart.LPN-J preformed hand hygiene, donned a gown, and gloves and provided for privacy. LPN-J brought the medication and the graduated cylinder into the room and next to the bedside of R11. LPN-J stopped R11's tube feeding machine and disconnected the line from R11's ET. LPN-J confirmed R11's ET placement with 10cc of air (by pushing air into the ET with a syringe and listening on R11's stomach to hear a woosh sound). LPN-J then pulled water into the syringe from the graduated cylinder and pushed the remaining air out of the syringe with a small amount of water dripping down the side of the syringe to measure 30 mL of water. LPN-J wiped off the syringe with the contained gloved hand, including the tip of the syringe that goes into R11's ET. LPN-J connected the syringe and attempted to flush the ET, but was unsuccessful and disconnected the syringe. LPN-J pulled more water into the syringe from the graduated cylinder, pushed out the remaining air and some water, to measure 30 mL, causing water to drip down the syringe. LPN-J wiped off the syringe with the contained gloved hand including the tip that goes into R11's ET. LPN-J connected the syringe and flushed the ET successfully. LPN-J pulled 30 mL of water into the syringe, pushed out the remaining air and some water (to measure 30 mL) causing some water to spill over the syringe. LPN-J wiped off the syringe with the contaminated gloved hand, including the tip that connects to R11's ET. LPN-J put the water into R11's crushed medication cup and began to mix the medication to get it to dissolve. LPN-J pulled the medication and water mixture into the syringe, and attempted to push the air out, but LPN-J voiced difficulty as the syringe was clogged. LPN-J pushed the water and medication mixture in and out of the syringe using the cup it was mixed in - in attempt to free the clog. LPN-J freed the clog from the syringe, pushed the air out, noted there was water dripping down the syringe, and wiped the syringe including the tip that gets connected to R11's ET with a contaminated gloved hand. LPN-J connected the syringe to R11's ET and attempted to flush, but LPN-J noted there was resistance and does not continue. LPN-J attempted to free the clog again by pushing the water and medication mixture into the cup that was used to mix the medication. LPN-J stated a spoon is needed. LPN-J did not remove PPE and opened the door to R11's room, and grabbed a spoon out of the shared spoon container on the nurses cart that is shared amongst all residents on the unit. LPN-J comes back into the room and closed the door. LPN-J did not remove PPE or preform hand hygiene. LPN-J used the spoon to mix the medication mixture. LPN-J drew up the mixture into the syringe and freed the clog. LPN-J pushed the remaining air out of the syringe and connected the syringe to R11's ET. LPN-J had resistance with pushing the medication and water mixture and stopped. LPN-J disconnected the syringe and discarded the medication mixture and the syringe and informed surveyor that LPN-J will re-attempt the medication administration for R11. LPN-J ran warm water in the sink, informing surveyor warmer water will be easier to dissolve the medication in. LPN-J removed gloves, and gown and preformed hand hygiene.LPN-J exits R11's room and retrieved another syringe. LPN-J preformed hand hygiene, pulled another medication for R11, and verified the medication. LPN-J crushed the medication and placed it into a cup. LPN-J preformed hand hygiene, applied a gown and gloves and entered R11's room and provided for privacy. LPN-J dumped out the previous water from the graduated cylinder and filled the graduated cylinder with warm water from the sink. LPN-J placed the medication and water at the bedside of R11. LPN-J checked R11's ET placement with 10cc of air, and confirmed placement. LPN-J filled the new syringe with water from the graduated cylinder and pushed the air and some water syringe (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out to measure 30 mL, some water flows over the syringe. LPN-J wiped off the syringe with a contained glove including the tip that is connected to R11. LPN-J connected the syringe to R11 and flushes the ET. LPN-J pulls water from the graduated cylinder into the syringe and pushed water and air out to measure 30 mL of water, and pushed the water into the cup with the crushed medication. LPN-J mixes the water and medication. LPN-J pulls the medication mixture into the syringe and pushed out the residual air. LPN-J connected the syringe to R11's ET and administers the mixture. LPN-J filled the syringe with 30 mL of water from the graduated cylinder and pushed out the air and some water, causing some to flow over the syringe. LPN-J wiped off the syringe with the contaminated glove, including the tip of the syringe that connects to R11's ET. LPN-J connected the syringe to R11 and flushes the ET. LPN-J connected the tube feeding line back to R11's ET and starts the machine. LPN-J dumps the remaining water in the graduated cylinder into the sink. LPN-J removes gloves and gown and preformed hand hygiene. LPN-J wiped off the stethoscope used on R11 and places the stethoscope into the water puddle on the nurse's cart from R11's graduated cylinder. LPN-J moves the medication cart in front of the next resident's room to begin another medication administration. LPN-J placed the stethoscope, that is contained from the water puddle on the nurse's cart, around the back of LPN-J's neck. LPN-J did not wipe down the nurse's cart. On 1/14/26, at 1:28 PM, Surveyor Interviewed LPN-J. Surveyor asked LPN-J if it's standard practice to bring the graduated cylinder from a resident's room and put it on the medication cart. LPN-J stated no, but LPN-J was so nervous and would not do that normally. LPN-J stated that the graduated cylinder should not leave the room. Surveyor asked LPN-J if there is a standard of practice to wipe off a syringe with a contaminated gloved hand prior to administration of fluids or medication to a resident with a ET. LPN-J stated no, and that LPN-J was nervous and does not recall wiping off the syringe prior to administering a medication. Surveyor asked LPN-J if LPN-J normally grabs items off of the cart while in contaminated PPE. LPN-J stated that LPN-J did not touch anything, so it was not an issue. Surveyor asked LPN-J if that is an infection control standard of practice. LPN-J stated no, and that LPN-J was nervous. On 1/14/26, at 2:02 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-N. Surveyor asked ADON-N if ADON-N is the infection preventionist in the building. ADON-N stated yes. Surveyor asked ADON-N if it is an expectation if a nurse has PPE on a room that has EBP, should the nurse remove PPE and preform hand hygiene before accessing the nurse's cart and anything outside of the room. ADON-N stated a nurse would need to remove PPE before exiting a room and before accessing anything outside of the room, especially a shared medication cart. Surveyor asked ADON-N if the graduated cylinder from a resident's room should be removed and placed on communal surfaces - like the nurse's cart. ADON-N stated no, a graduated cylinder is a care item specific to residents' and should not be removed from the room. Surveyor asked ADON-N if there is a standard of practice to wipe off a syringe, including the tip that is connected to a resident. ADON-N stated no, the nurse may wipe the outside with a paper towel or rinse in the sink, but nothing should be touching the tip of the syringe that connects to the resident. On 1/14/25, at 2:20 PM, Surveyor interviewed Director of Nursing (DON)-B with Nursing Home Administrator (NHA)-A present. Surveyor asked DON-B if it is a standard of practice to wipe off a syringe with a contained gloved hand prior to administering a medication through a resident's ET. DON-B stated no, the syringe should not be wiped off. DON-B also stated if the nurse felt it needed to be rinsed, the nurse should use the water from the graduated cylinder, wipe the outside with a paper towel, or rinse in the sink. Surveyor asked DON-B if the graduated cylinder from a resident's room should be removed and placed on communal surfaces - like the nurse's cart. DON-B stated the graduated cylinder should not leave the resident's room, and medications should be prepared at the bedside with the graduated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cylinder or at the nurse's cart with another source of water. Surveyor asked DON-B if it is an expectation if a nurse has PPE on a room that has EBP, should the nurse remove PPE and preform hand hygiene before accessing the nurse's cart and anything outside of the room. DON-B stated any time staff exit the room with EBP the staff are expected to remove PPE and preform hand hygiene. DON-B stated if a nurse needed to access something on the nurse's cart that is just outside of the resident's room, the nurse is expected to remove gloves and preform hand hygiene but may leave on the gown since the nurse is not fully out of the room. DON-B stated the nurse after obtaining an item from the nurse's cart must perform hand hygiene and apply gloves before resuming resident care. On 1/14/25, at 2:25 PM, Surveyor shared concerns about infection control during the administration of medication for R11. The facility has no further information to provide at this time.