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	01/28/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 1 (R1) of 3 residents reviewed for falls received adequate supervision and assistive devices to prevent accidents.R1 was admitted to the facility on [DATE] with recommendations to wear a helmet when out of bed or chair to prevent brain injury from falling or head trauma after having a craniotomy (a surgical procedure in which a neurosurgeon temporarily removes a section of the skull). R1's care plan for activities of daily living (ADLs) identifies the need for R1 to wear a helmet; dated 1/2/26. The facility assessed R1 being at risk for falls and did not place orders for R1's helmet until 1/20/26. The facility did not verify recommendations/orders with the physician to determined when R1 is to wear a helmet until 1/27/26.Findings include:The facility's undated policy titled, Use of Assistive Devices, documents the following:The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices, or those residents require equipment to maintain or improve function, dignity and quality of life.The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care.The facility will provide assistive devices, as indicated, for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement.Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices safely. This may include assessment, education or therapy sessions for training on the use of the device, set up assistance, supervision, or physical assistance as needed.A nurse with a responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed.The facility's undated policy titled, admission Orders documents the following:A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide written and/or verbal orders for the resident's immediate care and needs.The orders should allow facility staff to provide essential care to the resident consistent with the residents' mental and physical status on admission.The orders for providing information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and developed in interdisciplinary care plan.R1 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R1's diagnoses include chronic respiratory failure (low oxygen levels due to lungs not working properly), intracerebral hemorrhage (a type of stroke caused by ruptured blood vessel within the brain), dysphagia (difficulty swallowing from problems with the mouth and lips), muscle weakness, cognitive deficit (problems with thinking abilities like memory, attention, learning, reasoning, and judgment), cerebral infarction (stroke), Type 2 Diabetes (the body resists the effects of insulin leading to high blood sugar levels), aphasia (communication disorder caused by brain damage or a stroke), and hemiplegia (paralysis affecting one side of the body).R1's admission Minimum Data Set (MDS) completed on 12/28/25, assesses R1 requires substantial/maximal assistance with rolling right to left, and is dependent with toileting, showering, dressing, and transfers. R1 uses a manual wheelchair, has an indwelling catheter and is always incontinent of (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel. R1 requires insulin injections 7 days a week and is taking an anticonvulsant. R1 has had a fall in the last 2-6 months. R1 was assessed as having a Brief Interview for Mental Status (BIMS) score of 0, indicating that R1 has severe cognitive impairment.R1's admission MDS dated [DATE], documents the following Care Area Assessment (CAA):Falls CAA - R1 is at risk for falls related to history of falls prior to hospitalization, use of antidepressant, anti anxiety medication, and impaired mobility. R1 had a fall with his Cerebral Vascular Accident (CVA) prior to admission. R1 is receiving Sertraline for depression, alprazolam for anxiety, and opioids for pain. R1 is dependent upon staff for transfers via Hoyer due to a recent craniotomy. R1 is receiving therapy for strengthening and rehabilitation. R1 has had no falls since admission. Cognitive Loss/Dementia CAA - R1 is able to communicate by using thumbs up or down and pointing. This is not helpful during the BIMS assessment. There is no memory concerns, just lack of vocal ability.On 1/27/26, Surveyor reviewed R1's hospital discharge paperwork dated 12/22/25, which documents the following: Make sure to wear your helmet whenever you are out of bed or chair - if there are any falls or head trauma there is a risk of brain injury.Surveyor reviewed R1's orders which document the following:R1 to have helmet on when doing activity and out of bed (ordered date 1/20/26). Surveyor notes R1 was admitted on [DATE] and it did not have orders until 1/20/26 for R1's helmet. Surveyor also notes R1's orders did not reflect recommendations from R1's hospital discharge documents and R1's care plan did not get updated or reflect order written on 1/20/26.R1's care plan, dated 12/22/25, documents:*R1 has an Activities of Daily Living (ADL) self-care performance deficit related to stroke, hemiplegia, respiratory failure with stroke, and weakness (date initiated 12/22/25, revision 1/2/26).Interventions:Bed mobility - R1 is maximum assistance with bed mobility. R1 must have helmet on when on left side due to craniotomy (date initiated 1/2/26). Bed mobility - R1 is maximum assistance with bed mobility. R1 must have helmet on when on left side due to craniotomy, when out of bed and activities (revised on 1/27/26).Transfer - R1 requires mechanical lift Hoyer with two staff assistance for transfers (date initiated 12/22/25).*R1 demonstrates impaired safety awareness related to status post craniotomy, evidenced by intermittent removal of protective helmet after repositioning and transfer to wheelchair (date initiated 1/27/26).Interventions:R1 intermittently removes the helmet due to impaired safety awareness. Staff apply the helmet during repositioning and transfers, provide redirection and education, and monitor for safety (date initiated 1/27/26).Anticipate and meet R1's needs (date initiated 1/27/26).Explain all procedures to R1 before starting and allow R1 time to adjust to changes (date initiated 1/27/26).Provide calm verbal redirection and cueing regarding helmet use and safety risks (date initiated 1/27/26).Reapply helmet as tolerated (date initiated 1/27/26).R1's spouse educated on behavior, associated risks, and helmet use exceptions; spouse verbalized understanding and stated awareness and acceptance of behavior once R1 is seated (date initiated 1/27/26).*R1 is at risk for falls related to weakness (date initiated 12/22/25).Interventions:Be sure R1's call light is within reach and encourage R1 to use it for assistance as needed (date initiated 12/22/25).Ensure R1 is wearing appropriate footwear when ambulating or wheeling in wheelchair (date initiated 12/22/25).Keep needed items, water, etc. in reach (date initiated 12/22/25).*R1 has potential impairment to skin integrity related to immobility (date initiated 12/22/25).*R1 has potential impairment to skin integrity related to immobility, history of pressure injury to right ear and surgical incision scar to left lateral scalp (date revised on 1/12/26).Interventions:Surgical scar to skull. R1 must wear helmet when on left side (date initiated 1/12/26).Surgical scar to skull. R1 must wear helmet when on left side, out of bed and with activities (date revised on 1/27/26).Surveyor notes the following after reviewing R1's care plan:R1 did not have a bed mobility care plan until 1/2/26, which is 11 days after R1 was admitted on [DATE]. R1's care plan was updated on 1/27/26 with further instructions on how and when R1 is to wear R1's helmet. R1 transfers using a Hoyer lift, putting R1 at risk for head trauma while using the lift, and R1's care plan did not include R1 wearing a helmet during transfers until R1's care plan was revised on 1/27/26.The facility documents on 1/27/26, R1 having impaired safety awareness as evidence by R1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removing R1's helmet.R1's Kardex dated 1/27/26, documents the following:Bed Mobility - R1 is maximum assistance with bed mobility. R1 must have helmet on, when on the left side due to craniotomy.Dressing - R1 is totally dependent on 1 staff member for dressing and has a surgical scar to R1's skull. R1 must wear a helmet when on the left side.R1's Kardex dated 1/28/26, documents the following:Bed Mobility - R1 is maximum assistance with bed mobility. R1 must have helmet on, when on the left side due to craniotomy, when out of bed and activities.Dressing - R1 has a surgical scar to the skull. R1 must have helmet on, when on the left side, out of bed and with activities.Surveyor asked for copy of R1's Kardex at end of the day meeting on 1/27/26, at 2:06 PM. The facility provided Surveyor with a copy of R1's Kardex on 1/28/26 and Surveyor notes R1's Kardex was updated to reflect changes, on when R1 is to wear his helmet.On 1/27/26, at 12:12 PM, Surveyor interviewed R1 and R1's spouse. R1 was lying in bed supine with head of the bed at 45 degrees and grab bars present on both sides of R1's bed. Surveyor noted R1's bed to be in the middle of the room with both sides open and only the head of bed pushed up to the wall. Surveyor noted R1's helmet laying on R1's bedside table in the corner of R1's room out of reach. Surveyor asked R1 how R1 was doing and R1 nodded at Surveyor and gave a thumbs up. Surveyor asked R1 when R1 is supposed to wear R1's helmet. R1's spouse stated R1 is to wear a helmet with any movement such as rolling, being up out of bed, and during Hoyer lifts. R1's spouse stated R1 does not have part of R1's skull and it is just skin over R1's brain which is why R1 has the helmet. R1's spouse stated R1 went to the hospital via ambulance for scheduled doctor appointments on 1/19/26. R1's spouse met R1 at the hospital and was notified by ambulance staff that R1 had fallen when R1 was placed into a hospital wheelchair from the ambulance gurney. The seat on the hospital wheelchair fell forward with R1 being escorted down to the floor by ambulance staff with R1 being placed on R1's buttocks on to the floor. R1's spouse stated R1 did not sustain any injuries but then stated R1 did not have R1's helmet on at the time of the ambulance ride and fall. R1's spouse stated R1 will remove R1's helmet on their own and will often take off the helmet when sitting in the wheelchair. R1's spouse stated R1 and the family is ok with R1 removing the helmet when sitting in the wheelchair due to R1 having enough trunk strength. R1's spouse then stated R1 knows when R1 needs to wear the helmet but then stated R1 forgets to ask for the helmet because of the brain injury.On 1/27/26, at 12:49 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-F and asked CNA-F how she knows how a resident transfers and if equipment is needed. CNA-F states she refers to the care plan but was unable to locate the care plan binders at the nursing station. CNA-F stated she has worked at the facility for a while and is familiar with the residents. Surveyor asked CNA-F when R1 is to wear R1's helmet. CNA-F stated R1 is to wear a helmet when rolling in bed, during transfers, and during cares. CNA-F stated she got R1 ready on 1/19/26 for R1's doctor appointments and the ambulance staff transport. CNA-F stated she got R1 dressed and put on R1's helmet, and next thing she knew, the ambulance staff transferred R1 to the gurney and R1 was gone. Surveyor asked CNA-F if she witnessed ambulance staff transfer R1 to the gurney and CNA-F stated she did not see ambulance staff transfer R1 and then stated R1 can take on and off R1's helmet independently. CNA-F stated she is unsure if ambulance staff checked in with nursing staff prior to leaving the facility.On 1/28/26, at 10:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E by phone who stated she is familiar with R1 and recalls caring for R1 on 1/19/26. LPN-E stated CNA-F provided cares to R1 prior to ambulance staff showing up on 1/19/26. LPN-E stated CNA-F always makes sure R1 has R1's helmet on. LPN-E stated R1 will pull off the helmet all the time. LPN-E stated R1 will slide off R1's helmet independently and knows how to do it. LPN-E then stated it's not appropriate for R1 to remove R1's helmet if R1 is up in the wheelchair because R1 is supposed to have it on. LPN-E stated R1 is to have the helmet on when R1 is out of bed and up in the wheelchair. LPN-E stated R1 does not need a helmet on when R1 is in bed. Surveyor asked LPN-E where she would look to verify instructions on when R1 is to wear a helmet. LPN-E stated she will get report from the previous nurse, look at the 24-hour board, and look at orders. LPN-E stated the Treatment Administration Record (TAR) and/or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Administration Record (MAR) should indicate how and when R1's helmet is to be on. Surveyor noted to LPN-E that there were no orders for R1's helmet on 1/19/26 and asked how LPN-E knew when R1 was to wear R1's helmet. LPN-E stated she was told in report when R1 was admitted , and she carried on those same instructions when she cared for R1 and again referred to looking at R1's orders. LPN-E stated ambulance staff verified with LPN-E where R1 was going. LPN-E stated R1 had R1's helmet on and she's not sure when R1 removed the helmet. Surveyor asked LPN-E if she notified ambulance staff that R1 had a helmet and LPN-E stated she did not mention it to the ambulance staff because R1 had the helmet on when she last saw R1. LPN-E then stated she was passing medications to other residents within the facility at the time of R1 being transferred out by ambulance staff. LPN-E stated she was not aware of any falls when R1 was with ambulance staff on 1/19/26, and did not get report from the ambulance staff after R1 returned to the facility. Surveyor asked LPN-E who manages care plans and LPN-E stated care plans are not managed by floor staff. LPN-E indicated she does not know who enters in care plans for residents.On 1/27/26, at 2:06 PM, Surveyor asked Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, about the process when ambulance staff take residents to a scheduled appointment. NHA-A stated ambulance staff will check in at the front desk and the receptionist at the front desk will hand over the paperwork to the ambulance staff and call the nursing unit to let nursing staff know that transportation is at the facility. Ambulance staff will speak with the nursing staff prior to the resident leaving the facility. Surveyor asked NHA-A and DON-B when R1 is supposed to wear their helmet. DON-B stated the facility reviewed the referral from the hospital prior to R1 arriving at the facility. DON-B stated the referral indicated R1 was to wear the helmet when being repositioned to R1's left side. DON-B then stated the facility was not provided an actual order with the hospital discharge paperwork and stated there were only recommendations in the patient education portion of the hospital discharge paperwork. DON-B stated we communicated with staff to tell them what family had instructed the facility to do with R1's helmet. DON-B indicated R1's spouse doesn't want a helmet on when R1 is in the wheelchair. DON-B stated R1 and/or R1's spouse will take off R1's helmet once R1 is transferred into the wheelchair. DON-B then stated best practice is for R1 to have the helmet on when sitting in the wheelchair and stated again there were no discharge orders given by the hospital specifying R1's helmet, there were only recommendations. Surveyor asked what the current orders are for R1's helmet. DON-B stated R1's helmet should be on when up in the chair or if repositioning. Surveyor asked if the facility contacted R1's physician or the hospital to clarify the recommendations or to specify orders on when R1 is to wear a helmet. No further information was provided by NHA-A and DON-B regarding contacting R1's provider to specify orders.On 1/28/26, Surveyor reviewed R1's Progress Notes which document the following:Effective date 1/27/26, at 3:11 PM, created on 1/28/26, at 9:13 AM, DON-B contacted R1's Neuroscience Department to follow up on the instructions for R1's helmet and directions/orders for upcoming appointments and surgery.On 1/28/26, at 9:03 AM, Surveyor observed R1 in a high back wheelchair in the facility hallway waiting at the elevator with another staff member. Surveyor observed R1 not wearing a helmet and the facility staff member holding R1's helmet in his hand.On 1/28/26, at 10:43 AM, Surveyor interviewed DON-B who states R1's hospital paperwork had instructions on R1's helmet and did not have orders. DON-B stated there was no specific order to say when R1 was to wear R1's helmet. DON-B then stated she contacted R1's provider on 1/27/26, to get clarification on orders for R1's helmet. DON-B stated R1's provider indicated R1 is to wear a helmet when up in a chair and during activities, but the helmet is not needed when R1 is in bed. DON-B stated if there is no way R1 is going to fall, R1 won't need the helmet and stated the helmet is to be used during transfers, sitting in the chair, and during activities. DON-B stated the purpose of the helmet is in the event of a fall, to provide protection. DON-B indicated R1 does not like wearing the helmet and will take it off frequently. DON-B stated the facility was initially notified of R1 needing the helmet when turning R1 on the left side. Surveyor asked DON-B if she was aware of R1 having a fall during transport. DON-B stated R1's spouse notified the facility of R1 having (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a fall with ambulance staff while at R1's appointments outside of the facility. DON-B stated the facility contacted the ambulance company and obtained ambulance records which document R1 was assisted to the floor by ambulance staff when transferring to a wheelchair and R1 did not sustain any injuries. Surveyor asked DON-B if R1 was wearing a helmet at the time of the fall and DON-B stated she can't confirm if R1 was wearing a helmet at the time of R1's fall with ambulance staff outside of the facility. Surveyor shared the following concerns with DON-B: R1 is assessed as being at high risk for a brain injury with a fall after having a recent craniotomy. R1 was admitted on [DATE] with no orders for R1's helmet and the facility did not contact R1's provider to clarify recommendations or get orders for R1's helmet. R1's helmet was not care planned until 1/2/26. R1 did not have an order placed at the facility until 1/20/26. R1 was observed sitting in R1's wheelchair at the elevator without a helmet and a facility staff member was holding R1's helmet in their hand. The facility did not clarify orders/recommendations with R1's providers until 1/27/26. R1 was escorted out of the facility by ambulance staff on 1/19/26 and sustained a fall with ambulance staff. R1's spouse indicated R1 was not wearing a helmet at the time of the fall and facility staff cannot confirm what was shared with the ambulance staff to ensure R1's safety with what the expectations were for R1 wearing their helmet on 1/19/26.

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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 the medication error rate was below 5% for 1 resident (R5) of 3 observed receiving medications. The facility medication error rate was 6.89%. *R5 received one ergocalciferol oral capsule 1.25mg. R5's physician order documents ergocalciferol oral capsule 1.25mg, give 2 capsule by mouth in the morning every Wed (Wednesday) for vitamin D deficiency. *R5 received one zinc 50mg tablet. R5's physician order documents zinc-220 oral capsule, give 1 capsule by mouth one time a day. Findings include: On 1/28/26, at 7:32am, Surveyor observed medications being administered to R5. Medication Technician (MT)-G prepared 18 medications to administer to R5. Surveyor observed MT-G add one ergocalciferol oral capsule 1.25mg and one zinc 50mg tablet to the medication cup that R5 was to receive. Surveyor noted upon review of the Physician Orders the order for ergocalciferol oral capsule 1.25mg documents ergocalciferol oral capsule 1.25mg, give 2 capsule by mouth in the morning every Wed (Wednesday) for vitamin D deficiency and MT-G gave one. Also, R5 received one zinc 50mg tablet from the house stock and R5's physician order documents zinc-220 oral capsule, give 1 capsule by mouth one time a day., this is 170mg less than prescribed. On 1/28/26, at 9:47am, Surveyor interviewed MT-G and confirmed that one ergocalciferol oral capsule 1.25mg was given. MT-G showed Surveyor the medication card and on it was typed to give one capsule, Surveyor asked MT-G to look at the order in the computer and MT-G confirmed the physician order is for two capsules. Surveyor asked MT-G to look at the bottle for the zinc medication that was given. A 50mg bottle of zinc was shown. Surveyor asked MT-G to review the order in the computer and explained that zinc-220 indicates 220 mg of zinc per capsule and that only 50mg was given. On 1/28/25, at 10:47am, Surveyor interviewed Director of Nursing (DON)-B about the medication error rate being 6.89% with 29 opportunities. Surveyor explained the concerns of one ergocalciferol oral capsule being given and zinc 50 mg given, not the physician order of zinc-220. DON-B replied that pharmacy is following with medication pass once per month to audit the medication pass. No further information was provided regarding the medication errors observed.