Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525415	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menomonee Falls Health Services	N84 W17049 Menomonee Ave Menomonee Falls, WI 53051

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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: 525415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER: Menomonee Falls Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE: N84 W17049 Menomonee Ave Menomonee Falls, WI 53051	

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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	**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 1 resident was assessed to be clinically appropriate to self-administer medications.*R1 was observed with 6 medication pills in a medication cup on the over bed table next to R1 while R1 slept. R1 does not have a self-administration assessment completed identifying R1 was approved for self-administration of medications.Findings include:Policy . Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.ProceduresMedication Administration . 4.Medications are to be administered at the time they are prepared.5. The person who prepares the dose for administration is the person who administers the dose.9. Verify medication is correct three times before administering the medication.10. Residents are identified before medication is administered using at least two resident identifiers.13. Explain to resident the type of medication being administered and the procedure.14. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes.15. Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary (IDT), and in accordance with procedures for self-administration of medications and state regulations.19. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the medication administration record (MAR) is flagged. After completing the medication pass, the nurse returns to the missed resident to administer the medication.20. The resident is always observed after administration to ensure the dose was completely ingested. Documentation:1.The individual who administers the medication dose, records the administration on the resident's Medication Administration Record (MAR) immediately following the medication being given.R1 was admitted on [DATE] with diagnoses of Rhabdomyolysis (skeletal muscle breaks down rapidly), Chronic Kidney Disease (progressive damage and loss of function in the kidneys), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R1 is her own person.R1's electronic medical record does have a documented self-administration of medication assessment indicating R1 is not approved for self-administration of medications.R1's quarterly MDS (minimum data set) with an assessment reference date of 9/10/25 documents a BIMS (brief interview mental status) score of 14, which indicates R1 is cognitively intact for daily decision making.On 10/14/25, at 9:21 AM, Surveyor observed R1 sleeping in bed. Surveyor observed on the over bed table to the left of R1, a medication cup containing 6 pills. The pill cup contained 1 green, 1 white, 2 pink, and 2 yellow pills. Surveyor observed there was not a licensed nurse and/or medication tech in R1's room.On 10/14/25, at 9:50 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who confirmed LPN-C had passed medications to residents including R1. LPN-C confirmed LPN-C had left R1's medications on the overbed table while R1 was sleeping.On 10/14/25, at 9:53 AM, Surveyor observed R1's cup of 6 pills remains on R1's overbed table.On 10/14/25, at 12:01 PM, Surveyor observed R1's cup of 6 pills remains on R1's overbed table and R1 is not in the room. Surveyor located R1 down the hall to the right in the therapy gym.On 10/14/25, at 12:27 PM, Surveyor interviewed R1. R1 informed Surveyor the nurses usually wake up R1 to take R1's medications every day and was surprised to see R1's medications sitting on the overbed table this morning. R1 confirmed R1 administered the medications to herself upon returning from therapy. R1 explained R1 is a late riser.On 10/14/25, at 12:43 PM, Director of Nursing (DON)-B confirmed that medications should not be left at bedside if a resident has not been evaluated to self-administer medications.R1's October 2025 MAR (medication administration record) documents LPN-C checked and initialed (which indicates medication was administered) the following medication:Cholecalciferol 1000 tablet, Loratadine 10 mg, Oxybutynin 5 mg, Sertraline 25 mg, Vitamin B-12, Zestoretic 12.5 mg (hold if SBP is less than 100) with all medications documented of an administration time of 7:00 AM.On 10/14/25, at 1:37 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B R1's 7:00 AM medications had been left at the bedside for R1 and R1 has not been assessed to be able to self-administer medications. R1 did not take the medications until after 12:00 PM.No additional information was provided as to why the facility did not ensure R1 was clinically appropriate to self-administer medications.