

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Medical Suites at Oak Creek (the)		STREET ADDRESS, CITY, STATE, ZIP CODE  2700 Honadel Boulevard Oak Creek, WI 53154	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>09262</p> <p>Based on record review, interview, and facility policy review, the facility failed to provide three of three residents (Resident (R) 5, R15, and R17) written notification of room change as indicated in their facility policy of 17 sample residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Change of Room or Roommate, dated 03/07/23, revealed 5. The notice of a change in room . will be provided in writing .and will include the reason (s) why the move or change is required .</p> <p>Review of the document titled, Action Summary, dated 12/04/24 provided by the Administrator, indicated R5 had a room change on 12/03/24; R15 had a room change on 11/23/24; and R17 had a room change on 11/14/24.</p> <p>Reviews of R5, R15, and R17's electronic medical records (EMR) reviewed no documentation that the residents had been provided with written notification of the room changes.</p> <p>During an interview on 12/03/24 at 2:24 PM, the Social Worker (SW) confirmed that R5's EMR lack written documentation informing the resident of the room change.</p> <p>During an interview with the Administrator and Director of Nursing (DON) on 12/04/24 at 3:00 PM, both confirmed that R15 and R17's EMR lacked documentation that R15 and R17 received written notification of the room change. The Administrator stated that her expectation regarding room change would be that staff documented in the EMR progress notes, and that written notification of the room change would go in the EMR under the MISC [Miscellaneous] tab.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 09262</p> <p>Based on interview and record review, the facility failed to implement a physician order for one of one resident (Resident (R) 1) of 17 sample residents, to be Nothing by Mouth (NPO) prior to a scheduled surgery. Specifically, R1 consumed his breakfast meal prior to being transferred to the hospital, which caused the surgery to be canceled. This deficient practice caused the resident to experience emotional stress and delay in having hip surgery.</p> <p>Findings include:</p> <p>Review of R1's electronic medical record (EMR) Admission Record under the Profile tab revealed R1 was admitted to the facility on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/01/24 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated R1 had moderate cognitive impairment.</p> <p>Review of R1's Order Summary Report, dated 10/14/24 and provided by the Administrator, revealed NPO at midnight .Procedure scheduled for 10/18/24, arrival schedule for 10:45 AM. Arthroplasty hip revision .</p> <p>Review of R1's EMR Progress notes under the Progress notes tab, revealed documentation 10/18/24 .PT [patient] NPO at midnight .10/18/24 at 5:41 PM Resident returned from the hospital via stretcher .resident was set to have a scheduled surgery today. Surgery was canceled due to the resident eating breakfast .</p> <p>During an interview on 12/04/24 at 12:45 PM, R1's wife stated that she was very upset that R1 had to have his surgery canceled and then rescheduled. She stated that the nursing staff should have communicated better so that all staff knew R1 was not to have breakfast prior to being transferred to the hospital for his surgery.</p> <p>During an interview on 12/04/24 at 9:22 AM, the Administrator stated she learned that dietary was not notified of R1's NPO order, so dietary sent R1's breakfast tray on 10/18/24. She stated that the NPO order had not been communicated to the Certified Nurse Aides (CNAs) and that CNA1 gave R1 his breakfast tray. The Administrator stated that Licensed Practical Nurse (LPN) 7 was not notified that R1 had eaten his breakfast, so she sent him to the hospital on 10/18/24 for his hip surgery. The Administrator stated that the facility did not have a policy and procedure to guide nurses the procedure to follow for notifying dietary and nursing staff when a resident had a physician's order to be NPO. The Administrator also confirmed that she did not have any evidence that the facility's 24-hour report conveyed R1's NPO order.</p>		