

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 06/04/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, and policy review, it was determined the facility failed to ensure one of three residents (Resident(R)1) reviewed for abuse, neglect, and misappropriation was free from physical abuse. This does not ensure the protection of additional residents from abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect, and Exploitation, revised 05/19/25 revealed It is the guideline of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The facility has a zero-tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property.</p> <p>Review of R1's undated admission Record located in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including unilateral primary osteoarthritis of the left knee, age-related physical debility, and chronic kidney disease.</p> <p>Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/21/25, located in the EMR under the MDS tab, Brief Interview of Mental Status (BIMS), revealed R1's BIMS score is 15 out of 15 indicating the R1's is cognitively intact. R1 was assessed not exhibiting any behaviors. R1 was assessed as requiring partial/moderate assistance for personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands, excluding baths, showers, and oral hygiene.</p> <p>Review of R1's Nurse Note dated 03/30/25 at 6:49PM, located in the electronic medical record (EMR) under the Progress Notes tab, revealed Reported by aide assigned to resident, that resident accused her of grabbing her wrist. The writer and nurse assigned to resident went to investigate, and the resident stated aide grabbed my wrist when I asked her to apply the cream onto my knees. Upon assessment, no bruise, redness, ROM WNL (range of motion within normal limits). Denies pain/discomfort. Resident not in any distress .incident reported to DON and Administrator. Aide was sent home per facility policy.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's Facility Reportable Incident (FRI), written statement by CNA1 on 03/30/25, revealed R1 put her light on, I went to answer it. When I entered R1's room, the resident was cleaning her bottom with wipes. She asked me to put some cream on her knees. I explained to her if she can bend over in bed and clean her own bottom then she can reach her knees and apply her cream. She stated that she knows she can do it herself, but she wants me to do it because that is my job! I explained to her that my job is to assist with things she is not able to do. I then put her arm to her knees and stated that she could rub her knees, and she started telling me I was hurting her. But I was not, her arm was already at her knees. I just placed her hand on her knees. I did not grab or pinch her arm. RN1 reported to the Administrator on 03/30/25 immediately after she was informed of the incident. The facility reported the incident to the State Agency on 03/30/25 at 8:29PM. CNA1 was sent home immediately, pending investigation.</p> <p>During an interview with R1 on 06/03/25 at 9:55AM, R1 stated she has arthritis in both knees, and uses Icy Hot cream for discomfort. R1 stated she had rung the call light, when CNA1 entered the room, R1 asked politely for CNA1 to apply the Icy Hot cream to her knees. CNA1 proceeded to grasp her right wrist and pulled her hand to her right knee and stated, this is your knee, and you can apply it yourself. R1 was asked if she felt she was being abused? R1 stated she felt threatened by CNA1. R1 was asked if CNA1 hurt her? R1 stated her wrist was sore after the incident. R1 was asked if she felt safe in the facility? R1 stated this was the only time this had happened, and that she did feel safe. R1 was asked if she felt the facility acted appropriately to the incident? R1 stated yes, I do, there were a lot of people involved, even the police.</p> <p>During an interview conducted on 06/03/25 at 10:39AM Registered Nurse (RN)1, RN 1 was asked if she recalled the incident with R1 and CNA1 on 04/14/25? RN1 stated yes, she did recall it. RN1 stated that R1 called for help and asked for CNA1 to put the cream on her knees. CNA1 told R1 that you can reach your knees, why are you asking me to do it? CNA1 proceeded to reach out to R1's hand and put it on R1's knee, and told the resident See you can reach.</p> <p>During an interview conducted on 06/03/25 at 10:20AM, with CNA3, CNA3 stated that he took over her care from CNA1. R1 reported to the nurse that CNA1 grabbed her wrist when she asked the CNA1 to apply the cream. R1 is always asking CNAs to rub her knees with cream. CNA3 stated he does it but other CNAs will not.</p> <p>During an interview conducted with Licensed Practical Nurse (LPN)1 on 06/03/25 at 10:49AM, LPN1 stated she was R1's nurse at the time of incident. LPN1 stated that R1 called the nurses station and stated that CNA1 grabbed her arm and took her arm down to knee.</p> <p>During an interview conducted with the Director of Nursing (DON) on 06/03/25 at 10:34AM, the DON stated he would expect that the staff would have assisted R1. Even if she could do it herself, I would expect the staff to assist the resident.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and facility document review, it was determined that the facility failed to report the allegation of neglect for one of three residents (Resident(R)3) sampled for abuse, neglect, and misappropriation. This failure places all residents in danger of abuse, neglect, and misappropriation.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect, and Misappropriation revised 05/19/25, revealed The facility will have written procedures to assist staff in identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse .The facility will have written procedures that include Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement when applicable) when specified timeframe's: a. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .</p> <p>Review of R3's undated admission Record located in the EMR under the Profile tab indicates R3 was admitted to the facility on [DATE] and discharged on 05/03/25 with diagnoses including urinary tract infection, abnormalities of gait and mobility, and diabetes.</p> <p>Review of R3's admission MDS with an ARD of 04/24/25, located in the EMR under the MDS tab, revealed R3's BIMS score was 14 out of 15, indicating R3 was cognitively intact. R3 was assessed as not exhibiting any behaviors. R3 had impairment on both lower extremities. R3 requires partial/moderate assistance for toileting hygiene: The ability to maintain perianal hygiene, adjust clothes before and after voiding or having bowel movement.</p> <p>Review of R3's Grievance Summaries dated 04/20/25, provided by the facility, revealed R3 stated, at 5:00AM this morning she had her call light on for one hour to use the bathroom, the staff member came in and told her to use the bathroom in her Depends and she didn't come back. The resident received assistance around 8:00AM when her spouse arrived.</p> <p>During an interview conducted with the Administrator in Training (AIT) on 06/03/25 at 11:07AM, the AIT stated this was first interpreted as a grievance. The incident happened on 04/20/25 at 5:00AM, and the Director of Hospitality reported it to AIT. (Date unknown). After review by AIT and Administrator it was determined the incident should have been reported to the State Agency immediately as neglect. The incident was reported to the State Agency on 04/25/25 at 12:35PM. After submitting it to the State Agency we went through the entire investigation process. Unable to substantiate based on statements from other residents and CNA.</p> <p>During an interview conducted on 06/03/25 at 11:43AM with the Director of Hospitality (DH), the DH was questioned why she didn't report the allegation of neglect immediately? The DH responded the incident happened on Easter, and she went to meet with R3 and took down her complaint and submitted a grievance on 04/20/25. DH was questioned if she had considered this to be neglect or night? DH responded not at the time but understands why it is now.</p>		