STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525730	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Suites at Oak Creek (the)	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not complete neurological checks in accordance with policy and procedure for 2 (R3 and R4) of 2 residents reviewed for unwitnessed falls. *R3 sustained an unwitnessed fall on 6/27/25. Facility staff did not complete neurological checks in accordance with the facility's policy and procedure. *R4 sustained an unwitnessed fall on 6/9/25 and 6/23/25. Facility staff did not complete neurological checks in accordance with the facility's policy and procedure. Findings include: The facility policy dated 10/8/2024, titled Head injury (Neuro Checks) documents, in part: It is the guideline of this facility to report potential head injuries to the physician and implement interventions to prevent further injury . Assess resident following a known, suspected, or verbalized head injury. The assessment shall include, at a minimum: Vital signs, General condition and appearance, Neurological evaluation for changes . Evaluation of the head, eyes, ears, and nose for significant changes in vision, hearing, smell or bleeding . Pain assessment . Perform neuro checks as appropriate for event or resident risk factors, or per consultation by the physician. Example protocol for actual/suspected head injury may be: every 15 [minutes] for 1 hour, then hourly for 4 hours, then every 8 hours (every shift) for 72 hours. The facility policy dated 7/10/2024, titled Incidents and Accidents documents, in part: .In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol/[Post-Acute and Long-Term Care Medical Association] guidelines and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner . The facility undated Neurological flow sheet, which is part of the facility's fall packet, documents the following instructions: Vital Signs and Neuro checks: every 14 [minutes] x 1 hour. Every 30 [minutes] x 1 hour. Every hour x 4 hours, then Every 4 hours x 24 hours. (Progress along this time schedule only if signs are stable. *R3 was admitted to the facility on [DATE] with diagnosis that includes Stroke, altered mental status, Abnormal gait, Lack of coordination, and fall history. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE] documents R3 is severely cognitively impaired. R3 needs partial assistance for transfers and bed mobility. R3 has had a history of falls in the last 6 months. R3's Activities of Daily Living Care plan initiated on 6/26/25 documents the following intervention: [R3] requires minimal assist with two wheeled walker and gait belt, pivot for transfers. R3's Fall Risk Evaluation, dated 6/26/25 documents that R3 is at Moderate Risk for falls. R3's progress note dated 6/27/25 at 2:03 AM documents, in part: Resident found sitting on floor next to bed, back against nightstand. Resident had removed all clothing, gown, brief and gripper socks while on floor. Resident did not know what she was trying to do when she fell. Call light was in reach [and] was not on. No apparent injury [related to] fall. [Range of Motion] [Within Normal Limits]. Bilateral (both sides) hand grasp strong and equal. No external or internal rotation noted to [Bilateral Lower Extremities]. Resident denies pain at this time. R3's Physician Assistant progress note dated 6/27/25 at 1:54 AM, documents, in part: . [R3] . found sitting on the floor with [R3's] back to the nightstand. No pain, and no obvious injuries. Occurred at 1:30 am . Orders: . Fall precautions per facility protocol. Monitor with neuro checks per facility protocol . Surveyor noted the Physician Assistant recommended that facility staff monitor neuro checks per facility protocol. Surveyor reviewed the facility fall investigation for R3's fall on 6/27/25 at 1:30 AM. Surveyor noted R3's fall was unwitnessed. Surveyor reviewed R3's electronic medical record for documentation of completed neurological (neuro) checks after R3's fall. Surveyor located the following neurological checks: R3's had a completed neuro check on 6/27/25 at 2:06 AM, 2:10 AM, and 7:17 PM documented within the electronic medical record. Surveyor noted that new vital signs were not always completed by facility staff with each of the documented neuro checks. Surveyor noted that facility staff did not document any other neuro checks related to R3's unwitnessed fall on 6/27/25. Surveyor noted that the neuro checks were not completed per facility policy. *R4 was originally admitted to the facility on [DATE] with diagnosis that includes Congestive heart failure, Kidney failure, Diabetes Mellitus, Muscle weakness, Abnormalities of gait and mobility, and History of falls. R4's admission Minimum Data Set (MDS) assessment dated [DATE] documents that R4 is cognitively intact. R4 requires supervision/touching assistance for transfers and mobility. R4's Care Area Assessment for falls dated 6/3/25 documents: Care plan will be developed to assist resident to increase strength, endurance, safety awareness, and activity; minimize and manage cognitive and communication loss, and mitigate risk factors to prevent falls with overall goal to be free of falls and fall related injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's admission Fall Risk evaluation dated 5/30/25 documents that R4 is at moderate risk for falling. R4's Activities of Daily Living Care plan initiated on 5/30/25 documents the following intervention: [R4] requires assist of one with two wheeled walker with transfers. [R4] requires assist with wheelchair mobility. R4's progress note dated 6/9/25 at 5:50 AM documents, in part: writer notified resident had unwitnessed fall in room. Observed resident lying on [R4's] [Right] side on floor, next to bed. [R4] stated [R4] was attempting to ambulate and fell. [R4] does not recall if [R4] was using a [wheeled walker at] time of fall. Skin tear to [right] 5th finger, [treatment] applied. No [complaints of] pain, able to move all extremities freely. Shoes worn at time of fall, continent of bowel and bladder. Reminders given to use call light for all transfers, resident verbalized understanding . R4's MD progress note dated 6/9//25 at 5:41 AM documents, in part: . [R4] had a fall . [R4] struck her head against the bed. No complaints of headache, blurry vision . Orders: Fall precautions per facility protocol . Monitor with neuro checks per facility protocol . Surveyor noted the Physician recommended that facility staff monitor neuro checks per facility protocol. Surveyor reviewed the facility fall investigation for R4's fall on 6/9/25. Surveyor noted R3's fall was unwitnessed. Surveyor reviewed R4's electronic medical record for documentation of completed neurological (neuro) checks after R4's fall. Surveyor located the following neurological checks: R4 had a completed neuro check documented by facility staff in the electronic medical record on 6/9/25 at 6:25 AM. Surveyor noted that facility staff did not document any other neuro checks related to R4's unwitnessed fall on 6/9/25. Surveyor noted that the neuro checks were not completed per facility policy. R4 was discharged home from the facility on 6/12/25. On 6/20/25, R4 was readmitted to the facility after a fall at home. R4's admission MDS dated [DATE] documents R4 is cognitively intact. R4 requires substantial/maximal assist for transfers. R4 has a history of falls within the last month. R4's Fall risk evaluation dated 6/21/25 documents R4 is at moderate risk for falls. R4's Activities of Daily Living Care plan dated 6/21/25, documents the following intervention: The resident requires assist of one and gait belt for transfers. R4's progress note dated 6/23/25 at 12:19 AM, documents: writer notified resident self-reported falling. Observed resident lying in bed, skin tear noted to [left] forearm. Resident stated [resident] was attempting to self-transfer from bed and slid from edge of bed. Stated there was a puddle of water on the floor. Writer did not observe any spills. Gripper socks worn. [R4] denies hitting [R4's] head, able to move extremities freely. Denies pain. Encouraged resident to use call light for all transfers, resident verbalized understanding . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's MD progress note dated 6/23/25 at 12:49 AM, documents, in part: . [R4] sustained a fall. No injuries or complaints. Unwitnessed .Orders: Fall precautions per facility protocol . Monitor with neuro checks per facility protocol . Surveyor noted the Physician recommended that facility staff monitor neuro checks per facility protocol. Surveyor reviewed the facility fall investigation for R4's fall on 6/23/25. Surveyor noted R3's fall was unwitnessed. Surveyor reviewed R4's electronic medical record for documentation of completed neurological (neuro) checks after R4's fall. Surveyor located the following neurological checks: R4 had a completed neuro check documented by facility staff on a paper record on 6/23/25 at 12:23 AM, 12:38 AM, 7:08 PM, and 11:08 PM. Surveyor noted that facility staff did not document any other neuro checks related to R4's unwitnessed fall on 6/23/25. Surveyor noted that the neuro checks were not completed per facility policy. On 7/7/25 at 12:52 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-C. Surveyor asked when Neuro checks should be completed after a resident falls. LPN-C indicated that neuro checks are completed after an unwitnessed fall or a witnessed fall when the resident hits their head. Surveyor asked what is used to document neuro check assessments. LPN-C stated there is a neuro check flowsheet in the fall packet. The neuro checks are completed on paper and should be done every 15 minutes x 4, every 30 minutes x 4, every hour x 4 and then every 8 hours. On 7/7/25 at 3:02 PM, Surveyor asked Director of Nursing (DON)-B for the facility staff documentation of neuro checks completed after R3's 6/27/25 fall and R4's falls on 6/9/25 and 6/23/25. On 7/8/25 at 7:32 AM, DON-B returned to Surveyor and stated that DON-B realized that there was a problem with neuro checks not being completed as they should be. DON-B handed Surveyor a binder with education that was completed in the afternoon of 7/7/25. Included in the binder is a Quality Assurance and Process Improvement note documenting, in part: During a post-incident audit conducted on 7/7/25, incomplete or missing neuro checks were identified for three fall events . While no adverse outcomes were reported . these documentation gaps have been acknowledged as an opportunity for system level improvement. On 7/8/25 at 8:09 AM, Surveyor informed DON-B of the concern that R3 and R4's neuro checks were not complete and were missing after R3's fall on 6/27/25 and R4's falls on 6/9/25 and 6/23/25. DON-B stated that DON-B agreed. On 7/8/25 at 12:14 PM, Nursing Home Administrator (NHA)-A was informed of the above concerns. No further information was provided.

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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 interview and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 1 (R4) of 2 residents reviewed for falls. On 6/9/25, R4 was found by facility staff on the floor between R4's bed and wall. The facility did not thoroughly investigate the fall. Findings include: The facility policy dated 7/10/2024, titled Incidents and Accidents documents, in part: It is the guideline of this facility for staff to utilize . [the electronic medical record] to report, investigate and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident . The purpose of incident reporting can include: assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care . Licensed staff will utilize [the electronic medical record] to report incidents/accidents and assist with completion of any investigative information to identify root cause . The following incidents/accidents require an incident accident report but are not limited to: . fall . The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions . R4 was admitted to the facility on [DATE] with diagnosis that includes Congestive heart failure, Kidney failure, Diabetes Mellitus, Muscle weakness, Abnormalities of gait and mobility, and History of falls. R4's admission Minimum Data Set (MDS) assessment dated [DATE] documents that R4 is cognitively intact. R4 requires supervision/touching assistance for transfers and mobility. R4's Care Area Assessment for falls dated 6/3/25 documents: Care plan will be developed to assist resident to increase strength, endurance, safety awareness, and activity; minimize and manage cognitive and communication loss, and mitigate risk factors to prevent falls with overall goal to be free of falls and fall related injury. R4's admission Fall Risk evaluation dated 5/30/25 documents that R4 is at moderate risk for falling. R4's Activities of Daily Living Care plan initiated on 5/30/25 documents the following intervention: [R4] requires assist of one with two wheeled walker with transfers. [R4] requires assist with wheelchair mobility. R4's Fall risk Care plan initiated on 5/30/25 documents the following interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Follow facility fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's progress note dated 6/9/25 at 5:50 AM documents, in part: writer notified resident had unwitnessed fall in room. Observed resident lying on [R4's] [Right] side on floor, next to bed. [R4] stated [R4] was attempting to ambulate and fell. [R4] does not recall if [R4] was using a [wheeled walker at] time of fall. Skin tear to [right] 5th finger, [treatment] applied. No [complaints of] pain, able to move all extremities freely. Shoes worn at time of fall, continent of bowel and bladder. Reminders given to use call light for all transfers, resident verbalized understanding . Surveyor reviewed the facility's fall investigation packet completed by Licensed Practical Nurse (LPN)-D for R4's 6/9/25 unwitnessed fall. The second page of the fall packet is titled Fall Scene Investigation Report. Surveyor noted the date of the fall is left blank, the time of the fall is left blank, the staff/witness present at or finding resident after fall is left blank. Documented on the second page of the fall packet is that the fall occurred in the resident's room and the resident was found on the floor, and the fall was unwitnessed. The resident stated [R4] was ambulating to [R4's] bed. The root cause was resident not using assistive device [wheelchair] or walker [related to] unsteady gait. On 7/8/25 at 8:59 AM, Surveyor attempted to interview LPN-D by phone. LPN-D did not return Surveyor's call. LPN-D was not on the facility staff schedule during the survey and was not available for an in-person interview. The last page of the fall packet is titled, Assigned [Certified Nursing Assistant (CNA)] fall investigation. Surveyor noted CNA-E signed this page and it is dated 6/9/25. Surveyor noted that the time of the fall is left blank. Surveyor noted CNA-E answered some questions, including the following, in part: CNA assigned to resident at the time of the fall? CNA-E answered CNA-F. What time was your last interaction with resident? CNA-E answered [Not applicable] N/A. What was your last interaction with resident. CNA-E answered N/A. Where was the resident during the interaction? CNA-E answered N/A. What was the resident doing? CNA-E answered N/A . What is the resident toileting plan? CNA-E answered N/A. When was the resident last toileted? CNA-E answered N/A. Were assistive devices within reach? CNA-E left this answer blank. Was Call light within reach, phone within reach, water within reach? CNA-E left this answer blank . On 7/7/25 at 12:58 PM and on 7/8/25 at 9:02 AM, Surveyor attempted to interview CNA-E by phone. CNA-E did not return Surveyor's call. CNA-E was not on the facility staff schedule during the survey and was not available for an in-person interview. Surveyor noted that there were no other CNA statements included in the fall packet. Surveyor noted CNA-F was mentioned in CNA-E's statement, but the facility did not include a statement from CNA-F in the fall investigation. On 7/8/25 at 9:00 AM, Surveyor attempted to interview CNA-F by phone. CNA-F did not return Surveyor's call. CNA-F was not on the facility staff schedule during the survey and was not available for an in-person interview. Surveyor noted that the last time resident was seen, what the resident was doing prior to the fall, when the resident was last toileted, whether the call light was within reach, whether the call light was on or off, and whether fall interventions were in place at the time of the fall were not addressed in the fall investigation. Surveyor concluded that R4's 6/9/25 fall was not thoroughly investigated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/7/25 at 12:29 PM, Surveyor interviewed CNA-G. Surveyor asked what a CNA should do if a resident falls. CNA-G stated that CNA-G would make sure that the resident was safe and get the nurse to assess the resident. CNA-G would help the nurse with any task after that. Surveyor asked what documentation is completed by the CNAs after a fall. CNA-G stated that there is a fall packet that includes a questionnaire that documents things like where the CNA was at when the resident fell, when the resident was last seen and toileted, and what could be done to prevent the fall from happening again. CNA-G stated that all the questions are supposed to be answered. On 7/8/25 at 8:09 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-H. Surveyor asked what the facility protocol is when a resident is found on the floor. LPN-H stated LPN-H would make sure the resident is safe and then call for a Registered Nurse to complete an assessment before moving the resident. LPN-H would complete vitals. LPN-H would update the MD and the resident's Power of Attorney if needed. LPN-H would complete the fall checklist and fall packet. Surveyor asked what type of information is included in the fall packet documentation. LPN-H stated that things like when the resident was last seen, what they were doing at the time of the fall, when the resident was last toileted, and if the resident's fall interventions were in place at the time of the fall. On 7/8/25 at 9:23 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what documentation is expected of nursing and CNA staff after a resident falls. DON-B stated that the expectation going forward is that all areas of the fall packet are filled out. DON-B indicated that CNAs should not answer questions with N/A but should fill out the questions thoroughly and completely. DON-B stated that DON-B began this role about 3 weeks ago and DON-B has started education on the expectations of falls and the investigation of falls. Surveyor informed DON-B of the concerns that R4 experienced an unwitnessed fall on 6/9/25 that was not thoroughly investigated. DON-B stated that DON-B agreed that it was not thoroughly investigated. On 7/8/25 at 12:14 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R4's unwitnessed fall on 6/9/25 was not thoroughly investigated. No further information was provided.