

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 10/03/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and document review, the facility failed to determine one of 30 sampled residents (Resident (R) 132) was safe in the self-administration of physician ordered medications. This failure had the potential for R132 to not take her medication and experience adverse effects of not taking the physician ordered medications.</p> <p>Findings include:</p> <p>Review of R132's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R132 was readmitted to the facility on [DATE] with diagnoses of congestive heart failure, chronic obstructive pulmonary disease, hypertension, and pain in left arm.</p> <p>Review of R132's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 08/09/25, indicated R132 was coded for a Brief interview for Mental Status (BIMS) score of 11 out of 15 which indicated R132 was moderately cognitively impaired.</p> <p>Review of R132's Care Plan located under Care Plan tab in the EMR indicated there was not a care plan developed for self-administration of medications.</p> <p>Review of R132's Physician Orders located under the Orders tab in the EMR indicated there was not an order for R132 to self-administer medications.</p> <p>During an observation on 10/02/25 at 9:52 AM, Registered Nurse (RN)2 prepared the resident's medications and placed them into the medicine cup for R132. R132 held the cup of medicine in her hand and requested Tylenol. RN2 left the room, and the resident took her own medication. RN2 had her back to the door so that she could obtain the extra strength Tylenol from the medication cart in the hallway. The privacy curtain was drawn and RN2 was unable to observe R132 taking the medication in the medicine cup.</p> <p>During an interview on 10/02/25 at 9:59 AM, RN2 reviewed the EMR and confirmed R132 did not have an order for self-administration of medications. RN2 stated, The nurse is to observe the resident take the medications before leaving the room.</p> <p>During an interview on 10/02/25 at 12:40 PM, the Director of Nursing (DON) was asked if R132 could self-administer medications and the DON stated, No, she [R132] cannot. The nurse should have stayed in the room and observed the resident taking her [R132] medications or taken the pills with her [RN2] when she [RN2] left the room to get the extra Tylenol the resident wanted.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy Resident Self-Administration of Medication dated 04/17/25 indicated, &hellip;Each resident is offered the opportunity to self-administer medications during the routine assessment by licensed nurse and/or the facility's interdisciplinary team. Resident's [reference will be documented on the appropriate form and placed in the medical record&hellip;</p> <p>Review of the facility's policy Medication Administration dated 04/09/25 indicated, &hellip;Observe resident consumption of medication&hellip;</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure baths or showers were provided according to the schedule for three of three residents (Resident (R) 109, R7, and R48) reviewed for bathing out of 30 sample residents. This failure had the potential to result in the residents not maintaining adequate hygiene to prevent odor and skin infections. Findings include: Based on record review, interviews, and facility policy review, the facility failed to ensure baths or showers were provided according to the schedule for three of three residents (Resident (R) 109, R7, and R48) reviewed for bathing out of 30 sample residents. This failure had the potential to result in the residents not maintaining adequate hygiene to prevent odor and skin infections.</p> <p>Findings include:</p> <p>1. Review of R109's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include end stage renal disease, type two diabetes, ascites, absence of right left knee, and sleep apnea.</p> <p>Review of R109's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 08/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R109 was cognitively intact.</p> <p>Review of the annual Care Area Assessment (CAA) Triggers Summary, dated 02/27/25 and located under the MDS tab of the EMR, revealed R109 required substantial to maximum assistance for bathing.</p> <p>Review of the July 2025 Documentation Survey Report for bathing task, located under the Reports tab of the EMR, revealed R109 did not receive a weekly bath or shower on 07/03/25 and 07/10/25.</p> <p>Review of the August 2025 Documentation Survey Report for bathing task, located under the Reports tab of the EMR, revealed R109 did not receive a weekly bath or shower on 08/14/25.</p> <p>During an interview on 09/30/25 at 10:04 AM, R109 stated there was no hot water and no showers.</p> <p>2. Review of R7's Face Sheet located under the Profile tab of the EMR revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include fracture of upper end of right humerus, unspecified fall, dependence on dialysis, generalized edema, and anxiety.</p> <p>Review of R7's significant change in status MDS located under the MDS tab of the EMR with an ARD of 08/17/25 revealed a BIMS score of 15 out of 15 which indicated R7 was cognitively intact.</p> <p>Review of the annual CAA Triggers Summary, dated 02/27/25 and located under the MDS tab of the EMR, revealed R7 required partial to moderate assistance for bathing. R7 was dependent for tub/shower transfers.</p> <p>Review of the July 2025 Documentation Survey Report for bathing task, located under the Reports tab of the EMR, revealed R7 did not receive a weekly bath or shower on 07/04/25 and 07/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the August 2025 Documentation Survey Report for bathing task, located under the Reports tab of the EMR, revealed R7 did not receive a weekly bath or shower on 08/15/25. Bed baths were provided on 08/22/25 and 08/29/25 in place of a bath or shower.</p> <p>Review of the September 2025 Documentation Survey Report for the bathing task, located under the Reports tab of the EMR, revealed that R7 did not receive a weekly bath or shower on 09/12/25.</p> <p>During an interview on 09/30/25 at 8:35 AM, R7 stated there was no hot water in the shower and so a bed bath was provided.</p> <p>During an interview on 09/30/25 at 11:14 AM, Licensed Practical Nurse (LPN) 4 stated some of the rooms did not have hot water, so they had to take residents to a different shower room or use bucket water.</p> <p>During an interview on 10/01/25 at 8:45 AM, the Certified Medication Aide (CMA) stated she had to give the residents a basin bath sometimes because the sink had warm water.</p> <p>During an interview on 10/01/25 at 8:46 AM, Certified Nurse Aide (CNA) 2 stated she had to run the water for about 20 minutes to get some warm water and they have to do what we have to do. She stated she had to give a sponge bath to a resident while the resident sat on the toilet last week.</p> <p>During an interview on 10/01/25 at 3:15 PM, the Director of Nursing (DON) confirmed the missing shower documentation and was unable to confirm whether a shower or bath took place.</p> <p>3. Review of R48's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] following hospitalization for left tibia and femur fractures. She had diagnoses including pain, cramp and spasm, spondylosis (degenerative arthritis of the spine), dorsalgia (back pain), anxiety, and depression. Review of R48's admission MDS, with an ARD of 09/29/25 and located under the MDS tab of the EMR, revealed she scored 15 out of 15 on the BIMS, indicating intact cognition. R48 required substantial/maximum assistance with bathing and had not attempted to transfer to the shower/tub.</p> <p>Review of R48's Care Plan, dated 09/26/25 and located under the Care Plan tab of the EMR, revealed, The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] L [left] oblique tibial fx [fracture], L distal femoral fx. The approaches included: Bathing/showering: The resident requires max assist by 1 staff with showering weekly and as necessary.</p> <p>During an interview on 10/01/25 at 9:20 AM, R48 stated she felt dirty as she had not received a shower and had only one bed bath since her admission, but her hair had not been washed. She was lying in bed in a hospital gown and her hair appeared greasy and stringy. Review of R48's POC [Point of Care] Response History, located under the Tasks tab of the EMR, revealed from 09/24/25 through 10/03/25, R48 had not received a shower or bed bath.</p> <p>Review of R48's Documentation Survey Report, dated September 2025 and provided on paper, revealed R48 had not received a shower or bed bath.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/25 at 3:30 PM, Unit Manager (UM) 2 stated she had heard a complaint from R48 two days ago that she had not had a bath or shower since admission. UM2 stated R48 had pain and mobility challenges due to her fractures, so bed baths would be most appropriate for her. UM2 stated she was under the impression R48 was receiving bed baths and did not know why it had not been done.</p> <p>During an interview on 10/03/25 at 5:04 PM, CNA5 stated he worked with R48 but had not offered her a bath or shower. He stated she may have been offered a shower at some point, but the water in the shower room was cold and she may have declined a shower because of that. CNA5 stated most residents chose a bed bath because of the cold water in the shower, but he had not offered R48 a bed bath.</p> <p>During an interview on 10/03/25 at 5:38 PM, the DON stated there was no reason why baths and showers were not getting done. The DON expected staff to offer a shower or bed bath per the resident's schedule and preference.</p> <p>Review of the facility's policy titled, Resident Showers, revised 06/11/25, revealed 1. Resident will be provided with showers as per request and within reasonable accommodation, or as per facility schedule protocols (at least offered weekly)&hellip;</p>

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to ensure two of seven residents (Residents (R) 48 and R158) out of a total sample of 30 received prescribed medications to manage pain. This failure resulted in harm for both residents. Findings include: 1. Review of R48's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] following hospitalization for left tibia and femur fractures. She had diagnoses including pain, cramp and spasm, spondylosis (degenerative arthritis of the spine), dorsalgia (back pain), anxiety, and depression.</p> <p>Review of R48's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/25 and located under the MDS tab of the EMR, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. R48 experienced occasional pain rated at four out of 10, which occasionally made it hard to sleep at night.</p> <p>Review of R48's Care Plan, dated 09/26/25 and located under the Care Plan tab of the EMR, revealed, The resident has acute pain r/t [related to] L [left] oblique tibial fx [fracture], L distal femoral fx. The goal was, The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date The approaches included: Identify and record previous pain history and management of that pain and impact on function. Identify previous responses to analgesia including pain relief, side effects, and impact on function . Monitor/document for side effects of pain medication. Provide the resident with reassurance that pain is time limited.</p> <p>During an interview on 10/01/25 at 9:20 AM, R48 stated when she first arrived to the facility from the hospital, none of her medications were here, and her pain was out of control. R48 stated she was in excruciating pain and had to be sent back to the emergency room for pain management. During the interview, R48 was tearful about the situation and stated that she went through all that pain unnecessarily.</p> <p>Review of R48's hospital Discharge summary, dated [DATE] and located under the Miscellaneous tab of the EMR, revealed, Pain control required multiple adjustments, including the addition of lidocaine [pain medication] patches, scheduled tizanidine [muscle relaxer], tramadol [pain medication], acetaminophen, and topical agents, as well as intermittent use of dilaudid [pain medication] for breakthrough pain and antispasmodics for leg spasms. The summary included orders for diazepam (a benzodiazepine medication used to treat a range of conditions, including anxiety, muscle spasms, and seizures), 5 milligrams (mg) every night and tramadol (pain medication), 100 mg every eight hours as needed and may take an additional 50 mg in between doses if needed for inadequate pain control.</p> <p>Review of R48's EMR under the &ldquo;Orders&rdquo; tab revealed admission orders, dated 09/23/25, for tramadol, 100mg three times a day for pain management and order, dated 09/23/25, for diazepam, 5mg at bedtime for anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R48's Clinical Progress Note, dated 09/23/25 at 5:49 PM and located under the Progress Notes tab of the EMR, revealed R48 rated her pain at seven out of 10 on admission and was highly anxious and emotional. Review of a Nurses Note, dated 09/23/25 at 11:43 PM and located under the Progress Notes tab of the EMR, written by Unit Manager (UM) 3, revealed, Resident had concerns r/t pain medication. Resident stated she arrived around [1:00 PM] 9/23/25, Writer called pharmacy and faxed medication list. Pharmacy stated the [sic] received med list but have no valid scripts for tramadol and diazepam. Writer updated resident, Tylenol [acetaminophen] given. Resident concerned her pain will be out of control soon and requesting to be sent to [emergency room].</p> <p>Review of R48's September 2025 Medication Administration Record (MAR), located under the Orders tab of the EMR, revealed an order for diazepam with a start date of 09/24/25. There was no record if this medication was offered on 09/23/25. The MAR also included an order for tramadol with a start date of 09/23/25; however, the box to record administration of the evening dose was blank. Additionally, the MAR documented orders for acetaminophen with a start date of 09/26/25; there was no record of an order for or administration of acetaminophen on 09/23/25.</p> <p>Review of an "INTERACT SBAR Summary for Providers," dated 09/24/25 at 12:02 AM and located under the "Progress Notes" tab of the EMR, revealed, the facility used a service called 3rd Eye to contact the on-call physician. The resident was transferred to the hospital ER before receiving a response.</p> <p>Review of R48's ER [Emergency Room] Documentation, dated 09/24/25 and located under the Miscellaneous tab of the EMR, revealed, [R48] . presenting to the emergency department from her subacute rehab for uncontrolled pain to her left knee. Per patient, she was recently admitted to the hospital for a femur fracture. Patient was discharged to a subacute rehab yesterday afternoon. However, the facility told her they do not have any pain medication to give her, so they sent her back to the ED [emergency department] for uncontrolled pain. Patient reports that the pain is primarily located in her knee. Review of a Nurses Note, dated 09/24/25 at 4:08 PM revealed, Resident returned to facility at [4:00 AM] from [emergency room] . Resident was treated in ER for uncontrolled pain. [Two] doses of tizanidine and 1 dose of dilaudid was given with relief. Resident is alert and oriented with no complaints of pain at this time.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/01/25 at 4:10 PM, the Pharmacist in Charge (PIC) at the facility's contracted pharmacy stated prescriptions, including diazepam and tramadol, were received from the discharging hospital on [DATE]; however, were not delivered to the facility until 09/24/25. The PIC was unable to determine the time the medications were delivered to the facility. The PIC stated even though the prescriptions were received from the hospital, they could not be filled until the resident was admitted into the system by the facility. The PIC stated the resident had not been entered into the system until the evening of 09/23/25. During an interview on 10/02/25 at 9:03 AM, Unit Manager (UM) 3 stated the day R48 was admitted, the nurse on duty (Licensed Practical Nurse (LPN) 7) reported to her that the hospital had never sent in her prescriptions to the pharmacy. UM3 stated R48's pain was out of control and the resident wanted to be sent to the ER to manage the pain. UM3 stated she was concerned about R48's pain and agreed she needed to go to the ER for pain management. Since the pharmacy did not have valid prescriptions, the facility could not access the prescriptions in the facility's emergency contingency kit. During an interview on 10/02/25 at 10:22 AM, LPN7 stated her shift 09/23/25 began at 7:00 PM on 09/23/25, and R48 had been admitted to the facility around 11:00 AM. LPN7 stated when she came on shift, R48 was in a lot of pain. LPN7 called the pharmacy but the pharmacy reported there were no valid prescriptions for R48. LPN7 stated at that time, R48 rated her pain at nine or ten out of ten, and added, I was [expletive] because she came in at 11:00 AM and it wasn't addressed. LPN7 added R48 was very upset about the situation and she [LPN7] reported the situation to UM3. She stated R48 was sent to the ER to get her pain under control, since there was no access to pain medication for R48. LPN7 explained that the discharging hospital had not faxed the prescriptions to the pharmacy, and she had to wait for the pharmacy to put the resident into their system. She stated she was unable to use the medication in the facility's emergency contingency kit because the pharmacy did not have a valid prescription and could not provide the authorization code needed to retrieve the medication. LPN7 stated that R48 needed to go back to the ER for adequate pain management and to get valid prescriptions for all ordered medications. During an interview on 10/03/25 at 11:50 AM, the Director of Nursing (DON) stated she was told the pharmacy did not have prescriptions from the hospital, yet the hospital had faxed the prescriptions to the pharmacy and so she was not able to obtain another set of prescriptions. The DON stated R48's pain was severe, and she had to be sent to the ER to get pain medication. The DON stated the facility staff were told they were unable to pull the medications from the emergency contingency kit, as the pharmacy did not have a valid prescription to authorize obtaining the medication. The DON stated the nurse should have contacted the Medical Director in this situation to obtain an emergency prescription.</p> <p>2. Review of R158's undated Face Sheet located under the Profile tab in the EMR indicated R158 was admitted to the facility on [DATE] with diagnoses of displaced comminuted fracture of shaft of humerus and left arm.</p> <p>Review of R158's Admission/Readmission/Routine Head-to-Toe Evaluation &ndash; V7 located under the Evaluations tab in the EMR, dated 09/26/25 indicated R158 was alert. Under Memory/Recall Ability it was documented that R158 could recall the current season, location of own room, staff names, and faces, and where they were. Review of R158's Care Plan located under the Care Plan tab in the EMR dated 09/29/25 indicated, [R158] is on pain/opioid medication therapy r/t RUE [right upper extremity] fx [fracture]. Interventions were, Administer ANALGESIC [sic] [pain] medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [sic] [every shift].</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R158's Nursing Progress Notes dated 09/26/25 at 3:04 PM indicated, [AGE] year female with hx [history] of ESRD [end stage renal disease] on hemodialysis, dm [diabetes mellitus] type 2 [sic]&hellip; who presented to ED [emergency department] following fall at home. She [R158] was evaluated by ortho [orthopedic] and was recommended for non-operative [sic] management with immobilization/sling and pain control&hellip;</p> <p>Review of R158's Admission/Readmission/Routine Head-to-Toe Evaluation &ndash; V7 located under the Evaluations tab in the EMR, dated 09/26/25 at 3:04 PM indicated R158's pain was assessed as being a 0 on a pain scale of 1-10. R158's pain goal was documented as being 0.</p> <p>Review of R158's Physician Orders revealed orders dated for 09/26/25 for Roxicodone 5 mg (milligrams) Give 0.5 tablet by mouth every four hours as needed for pain, Tramadol 25 mg give one tablet by mouth every six hours as needed for pain, and Acetaminophen 500 mg give two tablets by mouth every eight hours as needed for pain for seven days. Pain evaluation was also ordered on 09/26/25 to be completed every shift.</p> <p>Review of R158's Medication Administration Record (MAR) dated September 2025 indicated, Acetaminophen 500 mg two tablets were given on 09/27/25 at 10:46 PM, for pain documented as 8, on a zero to 10 scale. There was an E documented below the nurses' initials representing the medication was effective.</p> <p>On 09/28/25 at 10:53 AM, Acetaminophen 500 mg two tablets were administered to R158 for pain documented as 5. There was an E documented below the nurses' initials on the MAR representing the medication was effective in relieving R158's pain.</p> <p>On 09/29/25 at 4:51 PM, Acetaminophen 500 mg two tablets were administered to R158 for pain documented as 4. There was also an E documented below the nurses' initials on the MAR representing the medication was effective in relieving R158's pain.</p> <p>Further review of the nursing progress notes indicated no documentation to reflect an assessment for pain from admission on [DATE] through 09/30/25.</p> <p>Continued review of R158's &ldquo;MAR&rdquo; indicated no Roxicodone or Tramadol had been administered to R158 since admission on [DATE].</p> <p>On 09/30/25 at 11:56 AM Registered Nurse (RN)1 was overheard saying to R158, Your pain medication is not here yet from pharmacy, but I can give you some Tylenol for now.</p> <p>During an interview on 09/30/25 at 12:01 PM, R158 stated her pain was a 10 in her right shoulder. I have not had any pain medication, and I am in severe pain. I went to dialysis this morning and I told them I was in pain, and they gave me two Tylenol too. I don't know what is wrong here.</p> <p>During an interview on 09/30/25 at 12:06 PM, RN1 stated, I will have her [NAME] [Roxicodone] by three o'clock today. The scripts were given to the unit manager and were faxed to the pharmacy an hour and a half ago. The pharmacy says they did not get the fax. As soon as they are faxed to the pharmacy again and they [pharmacy] get them [scripts], it usually takes about two hours for a STAT [immediate] delivery to come. Then I will be able to give her [R158] the [NAME] [Roxicodone]. I gave her [R158] Tylenol for now.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/30/25 at 1:05 PM, R158 rated her pain as a 7 and stated her pain continues to hurt in her right shoulder. They keep telling me the medicine will be here after three today. R158 was noted to be restless in bed at this time.</p> <p>Review of R158's MAR indicated RN1 had not documented the administration of Tylenol to the resident, nor was the pain level documented.</p> <p>During an interview on 09/30/25 at 3:38 PM, Unit Manager (UM)1 stated, If the admission comes from the hospital, the hospital physician can use ecribes [electronic system to order medications] and that goes to our pharmacy. Today, we printed a blank script; gave it to the NP [nurse practitioner] and she filled it out for the Roxicodone and Tramadol. I faxed these to the pharmacy three times today because the pharmacy stated they had not received the scripts. We have the contingency machine that after we fax the order for a narcotic to the pharmacy and they receive the script then we can call the pharmacy and get a code to get the narcotic out of the box and give to the resident. I was not aware of the resident was not getting her pain medication.</p> <p>During an interview on 09/30/35 at 4:03 PM, RN1 stated, I did get the NP [nurse practitioner] sign scripts again this morning because I saw when I came in today the narcotics were not in the drawer. I gave them to [UM1] to fax to the pharmacy for me because I was extremely busy today. RN1 confirmed he had not received these narcotics from pharmacy. RN1 stated, No, I did not look in the contingency box. I really don't know what is in there. RN1 confirmed he had administered Tylenol earlier today at 12:06 PM and stated, I should have documented the first Tylenol that I gave today.</p> <p>During an interview on 10/01/25 at 8:47 AM, UM1 confirmed that R158's Roxicodone was delivered yesterday by the pharmacy and confirmed it was in the contingency supply which was also available for use since admission.</p> <p>During an interview on 10/01/25 at 08:55 AM, R158 stated, I am in pain now, but I feel better than I did yesterday after I received my pain medicine that I was supposed to be taking.</p> <p>During an interview on 10/01/25 at 4:10 PM, the Pharmacist in Charge (PIC) stated, The first script that we received for Roxicodone 5 mg and Tramadol 50 mg for [R158] was on 09/30/25 at 10:30 AM. Both scripts were dated 09/29/25 by the facility NP [nurse practitioner]. We did receive hospital discharge orders for this resident, but we did not receive any scripts from the hospital physician.</p> <p>During an interview on 10/03/25 at 7:15 PM, the Director of Nursing (DON) stated, Pain assessments should have been completed on admission for this resident. As soon as the nurses noted that the narcotics did not come from the pharmacy, then they should have called the pharmacy to see if the scripts were there. If they were not there, then the scripts should have been signed by the provider, and the nurse fax the scripts to the pharmacy right then. We have Roxicodone and Tramadol in the emergency supply here. The nurse would have to get an order from the provider, call the pharmacy and the pharmacy will give us a code to get the medication out.</p> <p>(continued on next page)</p>		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy Pain Management dated 02/05/25 indicated, The facility must ensure that pain management is provided to residents who require such services. Consistent with professional standards of practice… and the residents' goals and preferences… Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change or status occurs… the facility in collaboration with the attending physician/prescriber… and resident and/or resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual's pain beginning at admission… Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen…		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain a physician order prior to obtaining laboratory tests for one of one resident (Resident (R)98) out of a total sample of 30 residents. This failure had the potential of obtaining unnecessary laboratory testing from residents. Findings include: Review of R98's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R98 was readmitted to the facility on [DATE] with the diagnosis of an abdominal hematoma.</p> <p>Review of R98's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 06/18/25 indicated R98 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated R98 was moderately cognitively impaired.</p> <p>During an interview on 10/02/25 at 3:49 PM, Unit Manager (UM)1 stated, the [Power of Attorney (POA)] for [R98] emailed and stated that when the resident was discharged from the hospital on [DATE], the hospital doctor wanted her [R98] labs drawn. I reviewed the discharge summary, and it said on the CT [CAT] scan to follow up with abdominal CT scan if her hemoglobin was less than eight due to the CT scan in the hospital finding an abdominal hematoma. I spoke to the nurse practitioner, and she said to order a CBC [Complete Blood Count] every two weeks to monitor this. It looks like we started doing that on 08/18/25. UM1 stated Whoever orders the lab tests are responsible for putting the orders into PCC (Point Click Care).</p> <p>Review of R98's EMR revealed there were no physician orders for a CBC to be performed every two weeks nor were there any lab results.</p> <p>On 10/02/25 at 4:20 PM, the Director of Nursing (DON) requested the laboratory results. On 10/02/25 at 6:00 PM, the DON presented the laboratory test results of CBCs that were performed every two weeks, beginning 08/18/25.</p> <p>During an interview on 10/03/25 at 3:29 PM, the DON stated, The providers are able to put orders into PCC. If they do not, then the nurse that speaks to the provider will be responsible for placing these orders in PCC.</p> <p>During a phone interview on 10/03/25 at 4:09 PM, the Nurse Practitioner (NP) stated, I don't have access to put the orders into PCC. I remember talking to [name of UM1] about having these labs performed every two weeks.</p> <p>On 10/0/25 at 5:30 PM, the DON stated the facility did not have a policy on laboratory services.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility policy review, the facility failed to ensure food was palatable and served at a safe and appetizing temperature for five of 30 sampled residents (Resident (R) 7, R22, R48, R90, and R124) reviewed for palatability. This failure had the potential to lead to decreased oral intake and weight loss. Findings include: 1. Review of R7's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses of unspecified fracture of upper end of right humerus, anemia, and depression.</p> <p>Review of R7's significant change in status Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 08/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 was cognitively intact.</p> <p>During an interview on 09/30/25 at 8:37 AM, R7 stated the food was not hot and that they (the kitchen) did not use hot plates or a pellet system anymore.</p> <p>2. Review of R22's Face Sheet located under the Profile tab of the EMR revealed the resident was admitted [DATE] with diagnoses of heart failure, chronic kidney disease, and anemia.</p> <p>Review of R22's quarterly MDS located under the MDS tab of the EMR with an ARD of 09/06/25 revealed a BIMS score of 15 out of 15 which indicated R22 was cognitively intact.</p> <p>During an interview on 09/30/25 at 1:41 PM, R22 stated the food was a hit or miss and they were getting more cold meals. He stated something changed with the kitchen or delivery system.</p> <p>3. Review of R48's Face Sheet located under the Profile tab of the EMR revealed the resident was admitted on [DATE] with diagnoses of type two diabetes, anemia, and chronic kidney disease.</p> <p>Review of R48's admission MDS located under the MDS tab of the EMR with an ARD of 09/29/25 revealed a BIMS score of 15 out of 15 which indicated R48 was cognitively intact.</p> <p>During an interview on 10/01/25 at 9:20 AM, R48 stated the food was usually lukewarm.</p> <p>4. Review of R90's Face Sheet located under the Profile tab of the EMR revealed the resident was admitted [DATE] with diagnoses of adult failure to thrive, anemia, and acute kidney failure.</p> <p>Review of R90's quarterly MDS located under the MDS tab of the EMR with an ARD of 07/13/25 revealed a BIMS score of 15 out of 15 which indicated R90 was cognitively intact.</p> <p>During an interview on 09/30/25 at 12:45 PM, R90 stated the food was not warm when served, it's cold. She stated it took too long to get reheated, so she did not ask.</p> <p>5. Review of R124's Face Sheet located under the Profile tab of the EMR revealed the resident was admitted on [DATE] with diagnoses of type two diabetes and anemia.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R124's quarterly MDS located under the MDS tab of the EMR with an ARD of 07/09/25 revealed a BIMS score of 15 out of 15 which indicated R124 was cognitively intact.</p> <p>During an interview on 09/30/25 at 11:00 AM, R124 stated the food was cold when it arrived.</p> <p>Review of the Resident Council notes, provided by the facility, dated 08/15/25, revealed Dietary: Milk sitting out all day&hellip;Food is cold because it's not being delivered on time.</p> <p>An observation of the lunch tray line in the kitchen on 10/02/25 at 11:21 AM, revealed the meatballs were 181 degrees Fahrenheit (F), the vegetables were 160 degrees F, and the rice was 163 degrees F. At 11:27 AM, the fruit cup was 39.4 degrees F.</p> <p>During an observation on 10/02/25 at 11:36 AM, alongside the Food Service Director (FSD), a test tray was plated and placed on the cart for the 300-hall (first cart). At 11:55 AM, the cart with the test tray left the kitchen and arrived in the dining room at 11:57 AM. Staff started serving from the cart at 12:06 PM. The test tray was evaluated at 12:19 PM, alongside the DM, with around nine trays left to pass from the cart. The egg roll was 127 degrees F, the meatballs with sauce were 121.8 degrees F, the vegetables were 113 degrees F, the rice was 119 degrees F, and the fruit was 63 degrees F. The DM stated the expectation was for the cold items to be around 40 degrees F and the hot foods to be around 130 degrees F. He stated he did not know why the temperatures were so low.</p> <p>During an interview on 10/02/25 at 3:00 PM, the Registered Dietitian (RD) stated the residents were complaining of cold food more often. She confirmed there was no pellet system in place.</p> <p>Review of the facility's policy titled Food Preparation Guidelines reviewed 12/17/24, revealed &hellip;3. Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. This includes but is not limited to&hellip;d. Minimizing holding time prior to meal service. 4. Foods and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include&hellip;c. Serving hot foods/ drinks hot and cold foods/ drinks cold.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, document review, interviews, and facility policy review, the facility failed to ensure milk gallons were held at the proper temperature in the 300-hall dining room; failed to ensure the pantry refrigerator and the entire main kitchen were clean for one of two observed pantries and one of one kitchen; failed to ensure food was labeled, dated, and disposed of after expiration for one of two observed pantries; and failed to ensure holding temperatures for the tray line were monitored for proper temperatures for one of one kitchen. The failures had the potential to affect potential food borne illnesses and the potential of contamination for 115 of 116 census residents that take food by their mouth. Findings include: 1. During an observation of 300-hall dining room on 09/30/25 at 12:03 PM, there were two gallons of milk stored on the counter and not held on ice or refrigeration.</p> <p>During an observation of 300-hall dining room on 10/01/25 at 12:22 PM, there were two gallons of milk stored on the counter and not held on ice or refrigeration. The temperature of the milk was taken after meal service. The low-fat milk gallon was tested at 48.6 degrees Fahrenheit (F). The chocolate milk gallon was tested at 47.8 degrees F. The Licensed Practical Nurse (LPN) 5 verified and confirmed the temperatures.</p> <p>2. During an observation on 10/01/25 at 8:34 AM, the small pantry on the 400-hall had a refrigerator located on the inside to the right. The inside of the freezer was dirty with food debris and there was an undated, unlabeled brown liquid, frozen substance in an ice tray. The refrigerator had one ham and cheese sandwich with a date of September 12th. Two ham and cheese sandwiches were undated and unlabeled. There was one plastic cup with an unknown beverage, undated and unlabeled.</p> <p>During an interview on 10/01/25 at 8:36 AM, the Certified Medication Aide (CMA) 1 stated the kitchen was responsible for monitoring and cleaning the refrigerator. She stated she had no idea what was in the ice tray, it looked like coffee. She stated it looked disgusting. She stated the sandwiches should only be good for a day or two. She proceeded to throw out the undated and unlabeled sandwiches and the sandwich with the date of September 12th. There was a partial eaten sandwich in a baggie, and she proceeded to throw that partial sandwich into the trash.</p> <p>During an interview on 10/02/25 at 8:36 AM, the Food Service Director (FSD) stated the lock on the 400-hall pantry had been changed and he just got access. He stated he did not know when the lock was changed. The FSD confirmed that dietary was responsible for cleaning the refrigerators.</p> <p>3. During an observation of the main kitchen on 10/02/25 at 8:23 AM, the floor underneath the hot plate warming storage system and the hot food holding unit was dirty with food debris. The outside and inside of the sandwich station was dirty with food debris. At 8:54 AM, the flooring underneath the oven was dirty with brown grime and excess food debris. At 9:33 AM, the ice machine had some dirty brown areas along the hard white plastic surface on the inside. At 9:35 AM, the walls behind the two-pan sink and behind the mechanical food station were dirty with food spatter. The shelving below the mixer area was dirty with food spatter.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/02/25 at 9:40 AM, the FSD stated that the floor underneath the oven, definitely needs to be cleaned. He stated he thought it had been cleaned about a month ago. He stated the sandwich station may have been cleaned on Sunday, weekly. He stated the ice machine had been cleaned about a month ago. He stated the walls were not on the cleaning schedule. At 10:46 AM, the drinking glasses were observed. The glasses had a hard water film, along the inside of many of them. He stated they just changed to a soft water system for the dishwasher. He stated he was unaware of how to get the hard water stains off the glasses.</p> <p>4. Review of the food temperature logs provided by the facility revealed a column designated for Cook-End Temp and this column was filled out. The columns designated as Holding Temp for Temp one and Temp two were blank, throughout. Review of the records from 09/17/25- 10/02/25 for all three meals, revealed they were blank under the hot holding temperatures for Temp one and Temp two.</p> <p>During an interview on 10/02/25 at 11:17 AM, the [NAME] stated he never documented the temperatures from the start of tray line. He stated he only documented the cooking temperature. He stated he would take the tray line temperatures to make sure it was not cold, not below 140 degrees F, but did not document them.</p> <p>During an interview on 10/02/25 at 3:00 PM, the Registered Dietitian (RD) stated she completed a monthly sanitation inspection. She stated she had noticed the lack of cleanliness in the kitchen and pantry on 400-hall. She stated it had been an issue that had been brought to the facility's attention. She stated the 400-hall pantry used to have a key code lock, and then the number got changed. She stated the kitchen was supposed to monitor the refrigerator in the pantry. She stated the milk gallons were supposed to be in ice for proper practice.</p> <p>Review of the facility's policy titled, Food Safety Requirements, dated 03/26/25, revealed c. Refrigerated storage- foods that require refrigeration shall be refrigerated immediately&hellip;IV. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded&hellip;4. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards&hellip;d. Holding-staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA [Food and Drug Administration] Food Code and facility policy for food temperatures as needed.</p> <p>Review of the 2022 Food Code by the U. S. Food and Drug Administration, located at https://www.fda.gov/media/184685/download?attachment, revealed on page 73: Time/ Temperature Control for Safety Food&hellip;(A) Under refrigeration that maintains the food temperature at&hellip;41 degrees F [Fahrenheit] or less&hellip;, page 75 revealed &hellip;Time/ Temperature control for safety food shall be maintained: At&hellip;(1) 135 degrees F or above&hellip;(2) At&hellip;41 degrees F or less, and page 112 revealed Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils&hellip;(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch&hellip;(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility has no policy or procedure or schedule for cleaning the main kitchen including floors, walls, refrigeration units, ice machines, and equipment. In addition, the facility has no policy or procedure for checking temperatures of the food during the start of the food service, throughout and at the end of the food service.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate care with the hospice agency for one of one resident (Resident (R)127) reviewed for hospice services out of a total sample of 30 residents. This failure had the potential to increase the risk of resident needs not being addressed. Findings include: Review of R127's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R127 readmitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and dementia.</p> <p>Review of R127's significant change Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 08/21/25 indicated R127 had a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated R127 had severe cognitive impairment.</p> <p>Review of R127's Care Plan located under the Care Plan tab in the EMR dated 10/03/25 indicated R127 had a &hellip;terminal prognosis and is receiving hospice services. Interventions included &hellip;Observe resident closely for signs of pain, administer pain medications as ordered and notify physician immediately if there is breakthrough pain.</p> <p>Review of R127's Hospice binder located at the nurses' station which contained the Hospice Plan of Care indicated R127 was to receive visits from the Skilled Nurse (SN) and Home Hospice Aide (HHA) two times a week.</p> <p>Further review of the Hospice binder indicated there was no documentation for the SN during the week of 08/31/25 and 09/07/25. One visit was documented during the weeks of 08/24/25 and 09/14/25.</p> <p>Continued review indicated there was no documentation of the HHA visits during the week of 09/07/25. There was documentation of an HHA visit made on 09/03/25 but there was no further documentation indicating a second visit was made that week.</p> <p>During an interview on 10/03/25 at 1:33 PM, Licensed Practical Nurse (LPN)6 stated, The aide comes once a week and then the nurse comes once a week unless the resident has a change in condition, we will call them, and they will come out for an extra visit to check on her [R127].</p> <p>During an interview on 10/03/25 at 5:15 PM, the Director of Nursing (DON) stated, The unit manager of the unit that the resident[R127] is on is responsible for making sure the facility gets the documentation from the hospice agency of the visits that have been made. The DON stated the hospice staff came twice a week even though the supporting documentation was not available.</p> <p>The DON confirmed Unit Manager (UM)1 was not in the facility and was not available for interview.</p> <p>On 10/03/25 at 5:30 PM, the Administrator was notified of the need for a copy of the hospice contract for the agency that is seeing R127.</p> <p>Prior to the exit conference on 10/03/25 at 7:30 PM, the Administrator stated he called to get the contract But it is after hours, so I doubt that we will get a copy of it. I know we have a contract with them; I just cannot find ours.</p>		

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 10/03/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of policies and procedures , the facility failed to wear Personal Protective Equipment (PPE) when entering into a contact isolation room for one of two residents (Resident (R)56) and failed to follow infection control guidelines when administering medications to one of three residents (Resident (R)132) observed during the Medication Administration Observation out one of 30 total sampled residents. The facility also failed to review and/or revise the infection control policies in the facility annually. These failures had the potential for residents to be exposed to infections unnecessarily. Findings include: 1. Review of R56's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R56 was readmitted to the facility on [DATE] with the diagnosis of enterocolitis due to Clostridium Difficile (C. Diff) (an infection of the intestine).</p> <p>Review of R56's Physician Orders located under the Orders tab in the EMR indicated an order dated 09/19/25 for 1. Infection: C. Diff 2. Precaution Type: (contact)&hellip;</p> <p>During an observation on 09/30/25 at 11:32 AM, the Director of Maintenance (DOM) entered into R56's room to take a pair of earphones to R56 without PPE on. The DOM was observed touching the overbed table and as the DOM exited the room, he touched the footboard of R56's bed with his bare hand.</p> <p>During an interview on 09/30/25 at 11:38 AM, the DOM was asked if he saw the Contact Isolation sign on the door and the DOM stated, I did not see it on the way in. I should have dressed in PPE.</p> <p>During an interview on 10/02/25 at 11:37 AM, the Infection Preventionist (IP) nurse stated, They are supposed to be in full PPE which would include gloves and gown when going into a contact isolation room.</p> <p>During an interview on 10/02/25 at 12:40 PM, the Director of Nursing (DON) stated, I expect staff to apply PPE on before they enter the room and then take it off when they exit the room. They are to be aware of the signage on the door and to go by the directions on it.</p> <p>Review of the facility's policy Transmission-Based (Isolation) Precautions dated 06/04/24 indicated, &hellip;Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct and indirect contact with the resident or resident's environment&hellip; Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment&hellip; Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., C difficile&hellip;) &hellip;</p> <p>2. Review of R132's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R132 was readmitted to the facility on [DATE] with the diagnosis of congestive heart failure, chronic obstructive pulmonary disease, hypertension, and pain in left arm.</p> <p>(continued on next page)</p>		

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 10/03/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R132's Physician Orders located under the Orders tab in the EMR indicated an order dated 02/05/25 for Docusate Sodium 100 mg (milligram) give one capsule by mouth one time a day for constipation. Another order dated 02/06/25 for Aspirin 81 mg give one tablet by mouth one time a day for coronary artery disease.</p> <p>During a Medication Administration observation on 10/02/25 at 9:53 AM, Registered Nurse (RN)1 was observed pouring a capsule of Docusate Sodium and a tablet of Aspirin into her bare hands from the bottle and then placed the pills into the medicine cup. RN1 then handed the medicine cup with the pills in it to R132 to take. R132 took the medicine cup from RN1 and swallowed the pills.</p> <p>During an interview on 10/02/25 at 9:59 AM, RN1 was asked if she should have poured the pills from the bottle into her bare hands for R132 to take. RN1 stated, Well, I sanitized my hands before I started. But I guess, since you are asking, I should not have done that.</p> <p>During an interview on 10/02/25 at 11:35 AM, the IP nurse stated, They are supposed to pour the medication or pills from the bottle into the cap and then place it into the medication cup, never touching the medication.</p> <p>During an interview on 10/02/25 at 12:40 PM, the DON stated, They can either pour the medication into the cup and not touch the medications with their bare hands or put gloves on and then touch the medication with their hand.</p> <p>Review of the facility's policy Medication Administration dated 04/09/25 indicated, &hellip;Remove medication from source, taking care not to touch medication with bare hand&hellip;;</p> <p>3.During a review of the facility's infection control policies, the following policies that had not been reviewed and/or revised annually were:Antibiotic Prescribing Practices was last reviewed/revised on 05/29/24. Antibiotic Stewardship Program was last reviewed/revised on 05/29/24.Transmission-Based (Isolation) Precautions was last reviewed/revised on 06/04/24.</p> <p>During an interview on 10/03/25 at 7:15 PM, the DON stated, I know the infection control policies are to be updated annually but this is done on the corporate level here and I don't have control over that.</p> <p>Review of the facility's policy Antibiotic Stewardship Program dated 05/29/24 indicated, &hellip;The elements of the program and associated protocols are reviewed on an annual basis and as needed as part of the facility's review of the overall infection prevention and control program&hellip;;</p>		