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	05/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents' physician and/or residents' representative were notified of changes including accidents resulting in injury, need to alter treatment for 3 (R1, R5, and R14) of 30 residents reviewed. R1's physician was not made aware of/ consulted with regarding a 20 lb. weight loss between 3/25/2026 – 4/8/2026. R5's case manager was not notified of a fall with injury that occurred on 4/5/2026. R14's power of attorney (POAHC) was not notified on abnormal lab results or changes to R14's wounds. Findings include: The facility policy titled Notification of Changes last reviewed/revised 3/31/2025 documents: The purpose of this guideline is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident' representative when there is a change requiring notification. Changes of condition require an evaluation, by using the eINTERACT Change in Condition Evaluation ensures proper documentation and notifications have been made.Compliance Guideline:The facility must inform the resident, consult with the resident's physician and/ or notify the resident's family member or legal representative when there is a change requiring such notification.Circumstances requiring notifications include:1. Accidents .2. Significant change in the resident's physical . condition such as deterioration in health .3. Circumstances that require a need to alter treatment. 1.) R1 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, muscle weakness, cognitive communication deficit, dementia, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease (COPD). R1's admission Minimum Data Set (MDS) dated [DATE] documents that R1 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 13. The MDS documents that the facility assessed R1 needing assistance with meal setup and assistance of 1 staff member with activities of daily living (ADL's). The MDS documents that R1 had an order for regular diet with regular fluids. R1 did not have an activated power of attorney and made medical decisions and was discharged from the facility on 4/13/2026. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525730	A. Building B. Wing	05/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan documented nutritional risk related to COPD, chronic kidney disease (CKD) stage 3, obesity, and dementia, initiated on 3/27/2026 had the following interventions:- Administer medications as ordered. Monitor/Document for side effects and effectiveness.- Obtain and monitor lab/diagnostic work as ordered. Report results to medical doctor (MD) and follow up as indicated.- Provide and serve diet as ordered. Monitor intake.- Provide and serve supplements as ordered.- RD (Registered Dietitian) to evaluate and make diet change recommendations as needed.- Weigh as ordered or per facility protocol. Monitor for changes. R1's physician orders document:-Obtain weight upon admission then weekly for four (4) weeks. (Start: 3/26/2026) Surveyor reviewed R1's documented weights and noted R1's only weight documented was 183.8 lbs. on 4/8/2026. Surveyor noted there was no admission weight obtained for R1 on 3/25/2026. Surveyor reviewed R1's medication/treatment administration record (MAR/TAR) for March and April 2026 and noted staff documented weight not obtained for R1 on 3/26/2026 and 4/1/2026. Surveyor reviewed R1's nursing progress notes. Surveyor noted there is no documentation indicating R1 refused to have weights obtained. On 4/15/2026, at 10:06 AM, Surveyor interviewed RD (Registered Dietician)-G who stated an admission weight was not documented for R1 so RD-G reviewed R1's hospital discharge paperwork and noted R1's weight in the hospital was 203.7 lbs. RD-G stated RD-G did a nutritional assessment on R1 and initiated the care plan. RD-G requested a weight be obtained for R1. On 4/8/2026 when RD-G followed-up with R1, RD-G noted R1's documented weight on 4/8/2026 was 183.8 lbs. indicating a 20 lb. weight loss had occurred between 3/25/2026 – 4/8/2026 (14 days). RD-G stated RD-G requested a re-weight for R1 and R1's weight loss was discussed in the morning interdisciplinary team (IDT) review meeting but is not sure what happened after that regarding R1's weight loss. RD-G stated RD-G was never able to follow up because R1 discharged on 4/13/2026. Surveyor asked RD-G when should staff obtain a requested re-weight for a resident. RD-G stated a re-weight should hopefully be obtained within 24-48 hours preferably if not the same day requested. Surveyor asked RD-G if R1 refused to get weights checked. RD-G stated RD-G is unaware if R1 refused to get weights taken. Surveyor asked if RD-G contacted R1's physician regarding the weight loss. RD-G did not contact R1's physician and was waiting to see if the weight obtained on 4/8/2026 was accurate. On 4/15/2026, at 12:27 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-HH who stated when a resident admits to the facility, staff are to obtain a weight on the resident if able. LPN-HH was not able to recall if LPN-HH obtained a weight on R1 when R1 was admitted to the facility in 3/25/2026. LPN-HH did not recall R2 refusing anything during R1's admission in the facility. LPN-HH stated if a resident refuses treatment, nursing staff is to document in the progress notes what was refused, why, and what interventions were implemented. LPN-HH stated nursing staff would follow up with the certified nursing assistant (CNA) staff to verify if a weight was obtained and why if not obtained. Surveyor asked LPN-HH if a re-weight is requested, how are staff notified and when should the re-weight be obtained. LPN-HH stated a re-weight should be obtained and reported when able to get it and staff are usually notified of a needed weight by looking at the 24 hour board or being told and passed down in end of shift report if it was not completed on the current shift. Surveyor asked who (continued on next page)

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	05/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	normally would contact the physician regarding weight loss. LPN-HH stated nursing, or management could contact the physician. LPN-HH was not sure if R1's physician had been contacted regarding weights not being obtained or a weight loss having occurred for R1. Surveyor reviewed nursing progress notes and did not find documentation of notification to the physician or an eINTERACT Change in Condition form completed for R1's weight loss. On 4/15/2026, at 2:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Clinical nurse specialist (CNS)-B, and Director of Operations (DOO)-O. NHA-A stated R1 discharged from the facility before a re-weight could be obtained. Surveyor asked if R1's physician was notified regarding weights not being obtained until 4/8/2026 which identified a 20 lb. weight loss from the hospital admission weight. NHA-A does not recall if the physician was notified and would look into the concern. On 4/15/2026, at 2:39 PM, NHA-A was unable to locate documentation R1's physician was notified of R1's missed weights or a 20 lb. weight difference from R1's hospital discharge weight to R1's current weight obtained on 4/8/2026. No additional information was provided. 2.) R5 was admitted to the facility on [DATE] with diagnoses that include congenital hydrocephalus (water on the brain causing symptoms of cognitive difficulties like memory loss), contracture of bilateral upper extremities (fibrous tissue injury resulting in lack of movement in the arms), contracture of bilateral lower extremities (fibrous tissue injury resulting in lack of movement in the legs), osteoarthritis (OA) (tissue in the joints, break down causing pain, stiffness, swelling and reduced mobility), and history of fall and seizures. R5's Significant Change Minimum Data Set (MDS) completed on 4/2/26, documents R5 is dependent with all cares (including toileting, transfers, eating and dressing). R5 is frequently incontinent of bowel and bladder. R5 was documented as having a Brief Interview for Mental Status (BIMS) score of 9, indicating R5 has moderate cognitive impairment. Surveyor reviewed R5's Electronic Medical Record (EMR) and facility self-report which documents R5 having a fall on 4/5/26, at 6:00 AM. Surveyor reviewed R5's fall investigation dated 4/5/26, which documents the following: Certified Nursing Assistant (CNA)-1 (CNA- X) was performing cares alone on R5 with R5 lying in bed. CNA-1 (CNA-X) had R5 facing away from her at the time of cares and R5 rolled out of bed. CNA-1 (CNA-X) did not see R5 roll out of bed but heard R5 roll out of bed. All interventions were documented as being in place. Immediate interventions were documented as putting the bed in the lowest position and bilateral body pillows to be placed. The root cause was documented as R5 had a high fall risk requiring 2-person assistance, however, care was performed with 1 staff member. On 4/15/26, at 12:40 PM, Surveyor interviewed LPN-EE who stated she contacts a RN in the building (continued on next page)

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	05/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for an assessment with a fall or change in condition. On 4/15/26, at 8:58 AM, Surveyor interviewed Clinical Nurse Specialist-B who stated the expectation of every fall is to complete all checks listed below: *Fall Risk Assessment that includes when the resident was last seen, toileted, if interventions were in place and if immediate interventions were initiated. *Neuro checks *Vital signs *Skin assessment *Pain assessment *Notify Hospice, POA, MD and Case Manager *Root Cause *72-hour post fall assessment *Care plan interventions reviewed/evaluated/updated *IDT (Interdisciplinary Team) to meet to discuss fall On 4/14/26, at 1:47 PM, Surveyor interviewed Community RN Case Manager-BB who stated he was notified on 4/10/26 of R5 having a fall with injury on 4/5/26. Community RN Case Manager-BB stated it is an expectation for the facility to notify the community case manager with a significant change or a fall within 24 hours, and this did not happen with R5's 4/5/26 fall. Community RN Case Manager-BB stated R5 currently has bilateral splints to BLE's (Bilateral Lower Extremities) due to fractures. Community RN Case Manager-BB stated he was notified the CNA was changing R5 on 4/5/26, in R5's bed, and left the room to get washcloths and did not witness R5 falling from the bed. Community RN Case Manager-BB stated he thinks R5 can state whether R5 is in pain, but then stated, it is hard to say due to limited communication and cognition. Community RN Case Manager-BB stated he finds it difficult to communicate with R5 and is not sure if R5 understands when you talk with R5. On 4/16/26, at 3: 23 PM Surveyor notified NHA-A, Clinical Nurse Specialist-B and Director of Operations-O of concerns with R5's Community Case Manager was not notified of R5's fall with injury that occurred on 4/5/26 until 4/10/26. 3.) R14 was admitted on [DATE] and has a diagnosis of peripheral vascular disease. R14 has an activated Health Care Power of Attorney (HCPOA) R14 was assessed as having developed 2 unstageable pressure injuries on 12/15/25. On 12/26/25, at 6:13 PM, Wound Registered Nurse (RN)-L documented a change in 1 wound on the right coccyx. A picture of the right coccyx, with a date stamp of 12/18/25 at 6:12 PM, was noted by Surveyor. An accompanied note documents Assessed 12/22/25, at 10:45. The description documents a healed unstageable pressure injury. (continued on next page)

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	05/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was unable to locate any documentation in R14's medical record that R14's HCPOA was notified of the right coccyx wound being assessed as healed 12/22/25. Surveyor confirmed this through contact with R14's HCPOA. R14's 2nd Wound Assessment for the coccyx documented on 12/22/25, at 10:49 AM, with a picture time stamp dated 12/22/25, at 10:46 AM documents the wound measures 2.80 (centimeters) by 2.30 by 2.8. The wound bed has 90% slough and 10% red with moderate serous drainage. The peri-wound has erythema. There is undermining present between 12 o'clock and 1 o' clock 2 cm (centimeters) and between 5 o'clock and 6 o'clock 2 cm. The December 2025 Treatment Administration Record (TAR) documents: A start date of 12/22/25 to cleanse coccyx wounds with NS, (normal saline) skin prep to periwound, gently pack with silver alginate, and cover with bordered foam dressing. Change daily and as needed for unstageable. On 12/22/25 imagining was performed on the coccyx due to pain and wound decline. The results document they cannot exclude osteomyelitis. The coccyx wound has declined since the last assessment on 12/18/25. There is no documentation in the medical record on 12/22/25 that R14's HCPOA was notified of this decline in the wound with an infection, along with a treatment change. A Nurses Note dated 12/23/25 documents R14 is pocketing food and diet was downgraded to puree with nectar liquids. Surveyor notes there is a Diet Change Form dated 12/23/25 for puree and nectar liquids. There is no documentation R14's HCPOA was notified of this change of pocketing food and the diet change order on 12/23/25. R14's December 2025 TAR documents on 12/27/25 a change to the coccyx wound treatment. The treatment is to cleanse coccyx wounds with Dakins 1/4, pack with blue foam, (cut in spiral for easy packing) skin prep to periwound, and cover with bordered foam dressing. Change daily and as needed. Surveyor was unable to locate any documentation that R14's HCPOA was notified of this treatment change on 12/27/25. On 4/16/26, at 3:15 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B and Director of Operations (DOO)-O, Surveyor shared concerns with R14's infection treatments, wound treatments, and diet changes. On 4/20/25, at 11:55 AM, Nurse Practitioner (NP)-I and Clinical Nurse Specialist (CNS)-B met with Surveyor. NP-I stated there was discussions with R14's HCPOA related to treating the osteomyelitis and R14's HCPOA did not want R14 sent out (to the hospital) to be treated. Surveyor noted that R14's HCPOA informed Surveyor they were not informed there was an infection in the wound, and it was worse. NP-I stated hospice was discussed due to R14's coccyx wound is not being treated and they are pocketing food. There is no documentation R14's HCPOA was notified of the diet change. No additional information was provided.

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	05/07/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a resident's grievance was thoroughly investigated, pertinent findings or conclusions were documented and communicated to the resident. This was observed with 1 (R12) of 16 record reviews.* R12 voiced a grievance to the facility on 1/7/2026 related to R12 requesting referrals to 2 other Skilled Nursing Facility (SNF). There is no documentation the referrals were completed, or that the grievance findings or conclusion was communicated to R12.Findings include:R12 was admitted to the facility on [DATE] and readmitted on [DATE]. R12 is their own person.On 4/14/26, at 12:54 PM, Surveyor interviewed R12 in their room. R12 stated they voiced to facility staff they wanted a referral to move to another facility. R12 stated R12 provided the facility with the names of 2 skilled nursing facilities (SNF) R12 wanted a referral sent to. R12 stated that the facility has not provided R12 with any documentation these referrals were made. R12 stated this has been going on for months.R12's medical record documents a note dated 11/12/25 written by Social Worker (SW)-PP that documents: There were 2 referrals made.Surveyor noted there is no documentation of results of the referrals.Surveyor noted SW-PP is no longer employed at the facility and was unavailable for an interview.R12's medical record documents a note written on 1/14/26, by SW-K, that documents: 1 SNF had no beds available and the other SNF was still pending. No further documentation of results.SW-K is no longer employed at the facility and was unavailable for an interview.Surveyor reviewed the facility's Grievance Log which documents a Grievance Report on 1/7/26 for R12. The documented summary was from SW-K. The grievance documents the same information as the nursing note on 1/25/26; there is 1 SNF that has no long-term beds and 1 is still pending. SW-K documented that the grievance was resolved on 1/30/26 with R12. There is no documentation identifying who was contacted at the 2 SNF's, or what documents/paperwork was sent to these facilities as part of R12's referral request.Surveyor noted that R12 informed Surveyor that R12 has requested to see the documented referrals and has not seen them and does not know of the outcome of the second referral. On 4/15/26, at 11:56 AM, Surveyor interviewed current Social Worker (SW)-N. SW-N stated they were not aware of R12's SNFs referrals. SW-N stated they are new to the facility. SW-N stated there is a process for referrals and following up of grievances. On 4/16/26, at 3:15 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Clinical Nurse Specialist (CNC) -B and Director of Operations-O, Surveyor shared R12's grievance and follow-up concerns. No additional documentation was provided.

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	05/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not have evidence that all alleged violations of abuse were thoroughly investigated for 1 (R5) of 3 residents reviewed for allegations of abuse.On 4/5/26, Certified Nursing Assistant (CNA)-X performed cares independently with R5, and R5 rolled out of bed. R5 was evaluated in the emergency room (ER) on 4/9/26 with findings that did not correlate to the fall on 4/5/26 and with the bruising identified as potential abuse in the ER.Findings include:The facility's policy titled Abuse, Neglect and Exploitation dated 9/18/23, last reviewed 7/1/25, documents:Guideline:It is the guideline of this facility to provide protections 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.Definition:Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.Staff includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social and activity programs.Prevention of Abuse, Neglect and Exploitation:The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur.Identification of Abuse, Neglect and Exploitation: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 and certain resident to resident altercations.Possible indicators of abuse include, but are not limited to:Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body; Physical injury of a resident, of unknown source; Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and repositioning.Investigation of Alleged Abuse, Neglect and ExploitationAn immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.Written procedures for investigations include:Identifying staff responsible for the investigation; Exercising caution in the handling evidence that could be used in a criminal investigation; Investigating different types of alleged violations; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation.Protection of ResidentThe facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:Responding immediately to protect the alleged victim and integrity of the investigation;This should include staying with the alleged perpetrator to ensure no further contact (verbal or physical) until removal form the facility/environment.Examining the alleged victim for any sign of injury, including a physical (continued on next page)

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	05/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	examination or psychosocial assessment if needed; Increased supervision of the alleged victim and residents; Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;Protection from retaliation;Providing emotional support and counseling to the resident during and after the investigation, as needed; Revision of the resident's care plan if the residents medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.R5 was admitted to the facility on [DATE] with diagnoses that includes congenital hydrocephalus (water on the brain causing symptoms of cognitive difficulties like memory loss), contracture of bilateral upper extremities (fibrous tissue injury resulting in lack of movement in the arms), contracture of bilateral lower extremities (fibrous tissue injury resulting in lack of movement in the legs), osteoarthritis (OA) (tissue in the joints, break down causing pain, stiffness, swelling and reduced mobility), history of fall and seizures.R5's Significant Change Minimum Data Set (MDS) completed on 4/2/26, documents that R5 was assessed to be dependent with all cares (including toileting, transfers, eating and dressing) and frequently incontinent of bowel and bladder. The MDS documents a Brief Interview for Mental Status (BIMS) score of 9, indicating that R5 has moderate cognitive impairment.R5's Care Area Assessment (CAA) documents:Cognitive Loss/Dementia CAA: R5 has cognitive decline and needs limited to extensive assistance with Activities of Daily Living (ADL)s, mobility and bowel and bladder management. R5 is at risk for behaviors, poor communication and understanding. The plan is for nursing staff to monitor R5's behaviors and R5's ability to communicate with staff. The goal is for R5 to have minimal to no behaviors, optimal communication and understanding with all needs met while residing at the facility.Functional Abilities CAA: R5 needs extensive assistance with ADL's, mobility and bowel and bladder management. R5 is at risk for falls and skin breakdown. The plan is for nursing to monitor R5's safety and skin integrity. The goal is for R5 to remain free of falls and skin breakdown while residing at the facility.Urinary Incontinence CAA: R5 has incontinence and needs extensive assistance with ADL's, mobility and bowel and bladder management. R5 is at risk for urinary complications and skin breakdown. The plan is for nursing staff to monitor R5's urinary status and skin integrity. The goal is for R5 to remain free of urinary complications and skin breakdown while residing at the facility.Falls CAA: R5 receives psychotropic medications and needs extensive assistance with ADL's, mobility and bowel and bladder management. R5 is at risk for falls, with and without injury. The plan is for nursing staff to monitor R5's safety. The goal is for R5 to remain free of falls while residing at the facility.R5's care plan dated 6/22/22, documents: R5 is at risk for falls, accidents and incidents related to unawareness and safety needs. R5 will fall from the bed or chair as a behavior. R5 has been noted to throw themselves on the floor. R5 will be half in bed and half out of bed at times (date initiated 1/23/26, revised on 1/23/26).Interventions include: Bed to be kept in lowest position (date initiated 10/11/25); Body pillows to be placed on both sides of R5 while in bed (date initiated 10/11/25); Hourly rounding or placement in common areas for monitoring (date initiated 10/22/25); Use bilateral body pillows (date initiated 6/9/25); Use bilateral floor mats (date initiated 5/2/25); Use bolsters on bed (date initiated 10/1/25); Ensure bed brakes are locked (date initiated 6/22/22)l Ensure two staff members are present during cares and interactions with R5 (date initiated 1/18/25, revised 4/9/26); True low bed (date initiated 5/21/25, revised on 6/5/25).R5 has an ADL self-care performance deficit and limited physical mobility related to right intertrochanteric femur fracture status/post Open Reduction and Internal Fixation (ORIF), fall, acute blood loss anemia, GERD, constipation, insomnia, congenital hydrocephalus with a shunt, seizures and Osteoarthritis (OA) (date initiated 6/22/22, revised on 5/2/25).Interventions include:Personal Hygiene: Physical assist of 1 staff member (created on 6/22/22, revised on 10/5/22).Toileting: Assistance of 1 staff member with a bedpan and incontinence care (date initiated 6/22/22, revised on 7/14/24).Transfer: R5 requires a Hoyer lift with 2 staff assistance (date initiated 7/8/22, revised on 6/21/24).Surveyor reviewed R5's Electronic Medical Record (EMR) and facility self-report which documents R5 having a fall on 4/5/26, at 6:00 AM.Surveyor reviewed R5's fall investigation dated 4/5/26, which documents: Certified Nursing (continued on next page)

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	05/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (CNA)-X was performing cares alone on R5 with R5 lying in bed. CNA-X had R5 facing away from her at the time of cares and R5 rolled out of bed. CNA-X did not see R5 roll out of bed but heard R5 roll out of bed. All interventions were documented as being in place. Immediate interventions were documented as putting the bed in the lowest position and bilateral body pillows to be placed. The root cause of the fall was documented as R5 had a high fall risk requiring 2-person assistance, however, care was performed with 1 staff member. Staff interviews were collected from facility staff whom worked night shift from 4/5/26 to 4/8/26.A statement from Medical Director (MD)-NN documents: R5 exhibits impulsive behavior specifically history of forceful self-extraction from beds and chairs. These sudden movements combined with impaired judgement present an increased risk of falls. It is helpful to note that contractures create leverage on the bones. If R5 falls while a limb is contracted, the bone is much more likely to snap than a flexible limb would be. Chronic contractures severely limit R5's Range of Motion (ROM) and postural stability, making independent movement unsafe and increasing the physical stress on long bones during any sudden shift in position. Given R5's overall frailty and the mechanical stress caused by the aforementioned contractures and documented impulsive movements, R5 is a markedly increased risk for pathological, or trauma induced fractures.Surveyor noted that the facility's self-report documents staff interviews identified R5 exhibiting/verbalizing pain at the time of the fall on 4/5/26, but did not present with deformity, swelling or bruising.Surveyor noted that Licensed Practical Nurse (LPN)-Y documented R5 was exhibiting left ankle deformity on 4/7/26.Surveyor noted that the facility's skin assessment completed on 4/6/26 for R5 documents R5 having BLE bruising was not identified on the 4/5/26 skin assessment with no further updates to R5's physician.Surveyor noted that the facility documented a failure to escalate incident and failure to complete a 72-hour post fall documentation.On 4/16/26, at 7:25 AM, Surveyor interviewed RN/PM Supervisor-D who stated an RN assessment is required for residents that had a fall, prior to moving the resident and that neurological checks, pain assessment, skin checks and a resident statement are obtained after a fall. RN/PM Supervisor-D stated staff will then use a Hoyer lift to get the resident back in bed if appropriate after an assessment has been completed and that staff will then notify the resident's physician of the fall.RN/PM Supervisor-D stated nursing staff contacted her on 4/9/26 with concerns of R5 having a left ankle deformity. RN/PM Supervisor-D stated RN-Z was caring for R5 and noted left ankle deformity while performing cares. RN/PM Supervisor-D stated that she also noted R5 having +2 to +3 edema to BLE (bilateral lower extremities) with R5's left leg edema greater than right leg. RN/PM Supervisor-D also noted R5 having bruising to both lower extremities from the knees down and described the bruising as patches of bruising that are increased more to the left ankle and left foot. RN/PM Supervisor-D indicated bruising was a reddish-purple bruising with somewhat faded bruising noted on both lower extremities. RN/PM Supervisor-D and RN-Z noted a change in condition with R5's ankles on 4/9/25, and contacted hospice, APOA and the provider.RN/PM Supervisor-D stated the provider ordered STAT x-rays but later determined x-rays would take too long and the on-call provider advised R5 to be sent to the emergency room (ER) for evaluation. RN/PM Supervisor-D stated there wasn't much information in R5's medical record regarding R5's fall that occurred on 4/5/26. Surveyor asked RN/PM Supervisor-D the cause of R5's falls and RN/PM Supervisor-D responded that she is not sure why and then stated R5 is supposed to be an assist of two staff members and a buddy system. RN/PM Supervisor-D stated if a resident does not have good body coordination, that resident could roll right off the bed. RN/PM Supervisor-D also stated R5 will sometimes tell staff that R5 is not in pain when R5 is actually expressing pain by staff observations. RN/PM Supervisor-D stated R5 is not always accurate with responses, and it is hard to rely on R5's responses.On 4/15/26, at 10:22 AM, Surveyor interviewed CNA-X who stated that R5's usual body position is contracted in the fetal position with R5's knees approximately 10 -15 inches away from R5's chin. CNA-X stated R5 was excited to see CNA-X on 4/5/26, and R5 was attempting to wiggle her way out of bed. CNA-X stated she would go into R5's room and ask if R5 was ok. CNA-X stated R5 could not say if anything was wrong. CNA-X (continued on next page)

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	05/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she increased her rounding with R5 due to R5 consistently wiggling and attempting to roll out of bed. CNA-X stated she was working with R5 on 4/5/26 at 6:00 AM, and CNA-X stated she was performing cares on R5 while R5 was lying in bed. CNA-X turned away from R5 while performing cares and R5 then rolled out of bed. CNA-X did not see R5's actual fall from the bed. CNA-X only heard R5 fall.CNA-X stated she thought that R5 hit R5's head on the bedside table and rolled on to R5's body, on top of R5's legs. CNA-X immediately got two nurses who were at the nursing station. CNA-X stated R5 developed a bump on R5's head with no other noticeable injuries or bruising. CNA-X stated she also worked on 4/6/26 and provided cares to R5 and noted R5's BLE to have significant and noticeable bruising. CNA-X described R5's bruising to be splotchy from R5's knees to ankles which was a change from her previous shift on 4/5/26. CNA-X noted R5's BLE crackling on 4/6/26 when attempting to perform cares and stated she asked the nurse to assess R5 due to this change. CNA-X stated the nurse assessed R5 and noted crackling, and the nurse stated this was documented in R5's medical record and that the nurse directed CNA-X to proceed with dressing R5 and get R5 up for the day which required a Hoyer lift. Surveyor asked CNA-X to describe how staff utilize the Hoyer lift with R5's severe contractures. CNA-X responded that R5 is supported with R5's back and buttocks, depending on how R5 is adjusted in the Hoyer lift and stated that staff have to adjust R5's legs when putting R5 into the wheelchair so R5 doesn't sit on R5's legs or get them caught in the wheelchair. CNA-X stated the way R5's body is, R5 could easily sit on R5's legs with the Hoyer lift. When R5 is in bed, CNA-X stated, staff also have to be careful with the wedges for support.On 4/15/26, at 3:00 PM, Surveyor interviewed RN-DD who stated staff refer to the EMR and Kardex to determine the number of staff needed for assistance. RN-DD stated she was the charge nurse on 4/5/26 and was contacted by nursing staff to evaluate R5 post fall. RN-DD stated R5 was lying on the floor on the nightstand with R5's brief half on. R5 was on the floor lying on R5's right side of bed. RN-DD stated CNA-X indicated she was providing cares for R5 alone and reached to the nightstand when R5 rolled out of bed. RN-DD stated she performed neurological checks, pain assessment, skin check, contacted hospice and obtained vitals. RN-DD stated she rubbed R5's legs to see if R5 would wince and grimace. RN-DD stated R5 denied pain and noted no bruising to bilateral lower extremities. RN-DD stated facility staff assisted R5 back into bed using a Hoyer lift. RN-DD stated she saw R5 a couple of days later on 4/8/26 during the night shift and another nurse reported R5's legs looked broken, and RN-DD went to assess R5. RN-DD stated a CNA reported off to another nurse that R5's legs looked broken, and legs were really bruised up and looked different from when R5 fell on 4/5/26. RN-DD stated that sometimes bruising can take a few days and staff notified RN/PM Supervisor-D who performed an assessment and indicated R5's ankle appeared different.On 4/15/26, at 11:19 AM, Surveyor interviewed LPN-Y. Surveyor asked LPN-Y what the protocol is for a change of condition. LPN-Y responded she will assess the resident to determine if there are immediate needs, obtain a set of vital signs, perform a skin assessment and will notify the unit manager for further assessment. LPN-Y stated the CNA notified her on 4/7/26, that R5's ankle looked deformed. LPN-Y stated she did not observe skin changes or bruising. LPN-Y stated R5 is able to let staff know if R5 is experiencing pain and R5 denied pain at that time. LPN-Y then stated they dropped the ball and should have reported this new change in condition to R5's provider. LPN-Y then stated they were thinking R5's legs normally look like this and stated again, they dropped the ball and should have reported it. LPN-Y stated report that was given at the beginning of the shift reporting no changes for R5. R5 lays on R5's right side and left ankle, with a pillow normally between R5's legs or feet. LPN-Y stated it looked out of place like a joint popped out of place, but she wasn't sure because of R5's contractions. LPN-Y stated no bruising was noted to R5's BLE on 4/7/26. LPN-Y stated she did not report any changes to the next nurse. LPN-Y stated she felt terrible because the facility told her this was something that happened days ago and not reported. LPN-Y stated R5 rolled out of bed and was told someone had R5's bed up super high and she rolled out. LPN-Y stated R5 will swing R5's legs off the Broda chair and R5 leans a lot. LPN-Y stated I felt bad because I was one of the people that dropped the ball with (continued on next page)

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	05/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5.On 4/15/26, at 9:48 AM, Surveyor interviewed RN-Z who stated R5's contractures limits mobility and R5 is in the fetal position. R5 has moderate movement with upper extremities but does not have dexterity in fingers. R5's knees can be up to R5's chin at times depending on how R5 is adjusted in bed. RN-Z stated R5's feet are pointed down and to the center of R5's midline of body similar to drop foot. RN-Z stated he was working on the night shift 4/8/26 into 4/9/26, and it was shared in report that R5 had a fall with bruising on BLE, a knot on R5's head and R5 seemed out of it. Surveyor asked RN-Z if the nurse giving report indicated they contacted R5's provider with R5 being out of it, and RN-Z stated the previous nurse didn't say she contacted anyone regarding R5 is seeming out of it. RN-Z went and administered R5 medications on 4/8/26, at 10:00 PM, and noted R5 to be at baseline. RN-Z then stated the CNA notified him of change. RN-Z then went in R5's room to perform scheduled skin prep on R5's bilateral heels and noticed R5 grimacing and extensive bruising and swelling to both legs. RN-Z stated R5's left leg appeared twisted, and the right leg looked normal per contractures. RN-Z stated he notified the charge nurse with the changes noted to R5's BLE. RN-Z stated the charge nurse indicated this was a change and advised RN-Z to contact hospice and the provider.RN-Z stated the previous skin assessment performed on 4/6/26 had the same information that was assessed on 4/9/26. RN-Z stated there were no notes outside of giving report and everything was being shared by word of mouth. RN-Z stated bruising will develop over time and over several days. RN-Z stated R5 had long bruises to both legs that looked purple and both legs appeared to be swollen with R5's legs appearing to be red, some with purple and increased swelling. RN-Z stated R5's BLE edema increased when R5 got up from the bed with less blood return to the legs which started to be even more alarming. RN-Z stated he did not perform a full skin assessment and stated R5's arms were not exposed. RN-Z was able to view R5's legs due to performing skin prep on bilateral heels. RN-Z stated R5 was sent to the ER for further evaluation.On 4/14/26, at 12:55 PM, Surveyor interviewed Forensic Nurse-CC. R5 arrived at the ER for evaluation on 4/9/26, for left ankle deformity. ER staff noted R5 having extensive bruising underneath the chin, right forehead, right clavicle, left forearm and BLE's. Forensic Nurse-CC stated the ER was notified of R5 having a fall from bed on 4/5/26 that did not seem to correlate with the fall. Forensic Nurse-CC stated the hospice nurse arrived at the ER at the same time Forensic Nurse-CC arrived in the ER to evaluate R5. Forensic Nurse-C stated the hospice aide last saw R5 on 4/7/26 and noted bruising underneath R5's chin and right forehead.Forensic Nurse-CC asked R5 if anyone harmed R5, and R5 stated no, but then stated yes indicating someone had pushed R5. R5 was unable to state whether it was a resident or staff member who pushed R5. R5 denied pain at the time of evaluation when asked however, R5 would start moaning when ER staff picked up R5's BLE's. Forensic Nurse-CC stated she performed a skin assessment on R5 which documents:Round fingerprint bruise under chin, not on bony prominence; Significant intermittent bruising on left forearm and left wrist potentially from being grabbed; 3 to 4 finger like bruising impressions on right clavicle that were more vertical than horizontal; Left leg with significant bruising from just below the left knee. Mid-calf to the foot appeared swollen, echymotic and deformed; Right lower leg appearing swollen, echymotic and bruised.Forensic Nurse-CC stated, when staff picked up R5's left leg, it was floppy, and the left leg bent in half when being picked up. Forensic Nurse-CC stated all bruising was not on bony prominences. Forensic Nurse-CC reiterated that R5's knees, elbows, chin and shoulder bony prominences were free from bruising. Forensic Nurse-CC stated x-rays were performed and revealed bilateral proximal and distal tibia and fibula fractures on both legs. Forensic Nurse-CC stated the ER MD stated verbally to Forensic Nurse-CC that these are spiral fractures that indicate abuse. Forensic Nurse-CC acknowledged R5 having a history of fractures in the past and then stated the radiologist determined these were acute fractures. Forensic Nurse-CC stated police were contacted regarding allegations of abuse.On 4/16/26, at 11:16 AM, Surveyor interviewed NHA-A and Director of Operations-O who stated they were notified of a change in condition with R5 the morning of 4/9/26. NHA-A stated police showed up at the facility on 4/9/26, indicating the ER contacted police with suspicion of abuse. NHA-A stated the facility started an (continued on next page)

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	05/07/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigation on 4/9/26 and noted R5 with a fall on 4/5/26. The facility's investigation included staff statements from staff that took care of R5 from the time of the fall. NHA-A stated the facility did not suspect abuse. NHA-A stated the facility identified that CNA-X provided cares independently for R5 when cares are to be provided with two staff members. Director of Operations-O stated this wasn't a perfect fall investigation and the facility needed to make some changes.On 4/16/26, at 3:23 PM, Surveyor interviewed NHA-A, Clinical Nurse Specialist-B and Director of Operations-O. Director of Operations-O stated that there was a delay in the facility's response with R5's change in condition and then notification of change was not properly completed. Clinical Nurse Specialist-B stated R5 is truly an assist of one and CNA-X should have had another staff member with her. Surveyor asked how the facility protects residents with abuse allegations. NHA-A stated we should treat it as an injury of unknown origin. NHA-A then stated this was not abuse, it is an injury of unknown origin. Clinical Nurse Specialist-B stated R5 had hospice services and R5 will still get treatment and services even while on hospice care. Surveyor notified NHA-A, Clinical Nurse Specialist-B and Director of Operations-O that police notified the facility of possible allegations of abuse on 4/9/26, that the facility did not complete a thorough abuse investigation as the investigation did not include any resident interviews that were obtained, and staff statements were obtained from night shift only.No additional information was provided.

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility did not ensure a comprehensive assessment, including an analysis of findings to develop a plan care, was completed for 1 (R14) of 30 sampled residents.R14 had an Annual (comprehensive) Minimum Data Set (MDS) completed with an assessment reference date of 12/3/25. The MDS indicated R14 had changes in bladder continence and mobility. The MDS Care Area Assessments (CAAs) had areas that were not comprehensively reviewed to include a rationale of the R14's individual needs and summary analysis to develop a comprehensive plan of care for R14.Findings include:The facility's policy and procedure for Comprehensive Care Plans dated 2/5/25, revised 5/1/25 documented:Explanation and Compliance Guidelines: .2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.R14's Annual Minimum Data Set (MDS) assessment with an assessment reference date of 12/3/25 assessed R14 as understanding others and being able to be understood. Staff completed the cognitive assessment interview for R14 with a summary score of 03 indicating severe cognitive impairment. Staff also competed the summary score for mood and behavior for R14 indicating a severity score of 04 indicating R14 had trouble concentrating on things and moving slowly or being fidgety (not specified). No hallucinations or delusions were noted during the assessment or altered mental status. R14 did not demonstrate behaviors to include rejected of care. R14 was assessed as having no functional limitations in range or motion to upper or lower extremities and R14 utilized a wheelchair. R14 is assessed to need set-up assistance for eating and was dependent upon staff for all other activities of daily living now including oral hygiene. R14 was assessed as now needing substantial/maximal assistance for rolling in bed and was assessed as now being dependent upon staff for all other mobility with the exceptions of transferring to tub/shower and walking 10 feet which were assessed as not attempted due to medical condition or safety concerns. R14 was assessed as having a decline in bladder incontinence with a decline from occasionally incontinent to always incontinent. No toileting program is indicated for R14. R14 was assessed as having occasional pain that rarely interferes with day to day activities with a pain intensity rating of 04. R14 is assessed as having no swallowing disorder and no further weight loss. R14 is assessed as being at risk for pressure injuries and had 1 unhealed, stage 2 pressure injury R14 is assessed as having 3 venous or arterial wounds. R14's assessed treatments included nutrition or hydration program to manage skin problems, pressure injury care, application of nonsurgical dressings other than to feet, and application of ointments/medications other than to feet. R14 is not assessed as needing pressure reducing device for chair or bed and for needing a turning and repositioning program. Section J regarding R14's prognosis documents no - indicating R14 does not have a condition or chronic disease that may result in a life expectancy of less than 6 months.Section V - Care Area Assessment (CAA) Summary with a signature by MDS Registered Nurse (MDSRN)-HHH dated 12/5/25 indicated cognitive loss/dementia, urinary incontinence and indwelling catheter, behavioral symptoms, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use were triggered. Section V indicated all areas had decisions to proceed with care planning.R14's CAA for cognitive loss/dementia identified triggering conditions including R14's brief interview for mental status (BIMs) indicating severe impairment and the presence of behavioral symptoms occurring 1-3 days during the look back period. The CAA identifies this as an actual problem for R14. Nature of problem indicated staff assessment completed due to resident cognition. Resident does have dementia. Neurological factors documented is (continued on next page)

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alzheimer's Disease. Observable characteristics and extent of resident's cognitive loss indicated confusion, disorientation, forgetfulness. Mood and behavior indicated behavioral symptoms. Medical symptoms that can impact cognition indicated thyroid disorder, respiratory problems, psychiatric or mood disorder, diabetes, congestive heart failure. Pain and its relationship to cognitive loss and behavior is checked for indications that pain is present. Functional status and its relationship to cognitive loss indicated decline in continence. Other consideration checked interference with resident's ability to get enough sleep. The section for documenting input from R14 or family members is blank. Will cognitive loss/dementia - functional status be addressed in the care plan? Yes. The section for documenting the overall object is blank. The summary section to describe the impact of this problem/need on the resident and your rationale for care plan decision documented: cognitive care plan will address cognitive status and dementia. Surveyor noted the CAA does not identify what the objective of the plan of care for R14 was. Surveyor noted the CAA indicated incontinence decline as a functional status having impact on R14's cognition. This was not analyzed in the CAA and R14's plan of care was not revised to address R14's decline (Cross-reference F657). This CAA was completed by Social Worker-K on 12/5/25.R14's CAA for urinary incontinence and indwelling catheter identified triggering factor including ADL assistance was needed as indicated by R14 being dependent for toileting hygiene or transfer to toilet and R14 being always incontinent for urinary continence. The CAA documented this a potential problem/need for R14. Nature of the problem/condition did not include any documentation. Modifiable factors contributing to transitory urinary incontinence documented psychological or psychiatric problems and pain. No other factors that contributed to incontinence are checked on the CAA. Laboratory results were also blank. Diseases and condition documented included diabetes and depression. The type of incontinence was blank for R14. Medications checked included diuretics-can cause urge incontinence, anticholinergics-can lead to overflow incontinence, antipsychotics, antidepressants, and opioids. The section for input from R14 or family members/representative was blank. Will urinary incontinence. functional status be addressed in the care plan? Yes. The overall objective was improvement and avoid complications. The description of impact of this problem and rationale for care plan decision documented: Resident is a [AGE] year old female with pmhx (primary history) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed nursing assistants. Based on the following above (sic), will continue to care plan. This CAA was signed as completed on 12/4/25 by MDSRN-HHHReview of R14's plan of care for bladder incontinence indicated the type of continence R14 was not assessed or care planned. R14's care plan was updated with R14's change in bladder continence. R14's plan of care did not address the care R14 was to receive related to being always incontinent of bladder. R14's care plan did not include a plan to improve R14's continence status despite improvement being identified as an objective of proceeding to a care plan. (Cross-reference F657).R14's CAA for behavioral symptoms dated 12/5/25 identified a triggering condition as the presence of at least one behavioral symptom. This problem is identified as a potential problem for R14. The section for documenting the nature of the problem/need for R14 was blank. The sections for seriousness of the behavior problem, nature of the behavioral disturbance, medication side effects that can cause behavioral symptoms were all blank on the CAA. Illness or conditions that can cause behavior problems indicated long standing mental health problems associated with the behavioral disturbances, such as schizophrenia, bipolar disorder., pain and diabetes. Factors that can cause or exacerbate the behavior was blank. Cognitive status documented delirium and dementia. The section for other considerations was blank as was the section for input from R14, family members or representative regarding this care area. Will behavioral symptoms be addressed in the care plan? Yes. Improvement is indicated as the overall objective. The (continued on next page)

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	description of impact of the problem/need on the resident and the rational for care plan decision documented: proceed to care plan. This CAA was signed as completed by MDSRN-HHH on 12/5/25.Surveyor noted the CAA did not include review of all factors that may impact R14's behaviors to ensure they are addressed in a plan of care. The rational did not include an explanation of the impact behaviors have on R14 to assist with establishing a comprehensive plan of care for R14 that addressed the identified objective of improving R14's behavioral symptoms.R14's CAA for Falls identified triggering factors as R14 had a recent fall since admission or prior to the prior assessment and R14 received an antidepressant on one or more of the last 7 days. Antidepressant is indicated as a high risk drug. The CAA identified falls as a potential problem for R14. The CAA does not include a documented nature of the problem or need for R14. The sections for history of falling and physical performance were blank. Medications checked included antipsychotics, antidepressants, opioids, and diuretics. Internal risk factors documented circulatory/heart, anemia, angina, neuromuscular/functional; incontinence, seizure disorder, psychiatric or cognitive, agitation behavior, cognitive impairment, other dementia, anxiety disorder, depression, manic depression, schizophrenia, and pain are all checked. The sections for laboratory tests and environmental factors are blank as is the section to document input from R14, family members/representative. Will falls functional status be addressed in the care plan? Yes. The overall objectives were documented as improvement and avoid complications. The section to describe impact of this problem and rationale for care plan decision was: Resident is a [AGE] year old female with pmhx (primary history) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed nursing assistants. Based on the following above (sic), will continue to care plan. Surveyor noted the documented impact and rational was the same documented rationale for other CAAs. The CAA for falls was signed as completed on 12/4/25 by MDSRN-HHH.R14's Care Area Assessment (CAA) triggered for nutrition dated 12/4/25. Triggering conditions were R14's BMI (body mass index), R14 receiving a mechanically altered diet and the diet is therapeutic as a nutritional approach and R14 has 1 stage 2 pressure injury or higher that is not healed. The analysis of finds indicate this is an actual problem for R14. Nature of problem/condition is documented as triggered r/t (related to) obesity, hx (history of) weight loss but weight stabilizing over the past couple of months, triggers r/t mech soft (mechanical soft consistency)- ground meats due to dysphagia. Triggers r/t Boost supplement use for nutrition support and weight maintenance. No current eating patterns are identified. Functional problems that affect ability to eat is identified as need for special diet or altered consistency which might not appeal to resident. Cognitive, mental status and behavior problems that can interfere with eating indicated other dementia, disruptive behaviors, throwing food, poor memory, and anxiety problems. No communication problems are identified. Dental/oral problems indicated include broken or fractured teeth. Other diseases and conditions that can affect appetite or nutritional needed indicated anemia, cardiovascular disease, depression, pain, thyroid problem, diabetes, and respiratory disease. The CAA does not indicate any abnormal lab values. Medications identified included antipsychotics and diuretics. No environmental factors are documented. The is no input documented from R14 or POAHC-CCC. Care plan considerations documented maintain current level of functioning. Dietitian-FFF did not document a summary or rationale for care plan for R14. This CAA was documented as completed on 12/4/25 by Dietitian-FFF.R14's Care Area Assessment (CAA) triggered for pressure injury dated 12/4/25 indicates the pressure injury CAA was triggered due to R14 having bowel and bladder incontinence, being at risk for pressure injuries with a stage 2 pressure injury, and R14's assessed need for mobility assistance in bed requiring substantial assistance and being dependent upon staff to lie down and sit up. Analysis of findings identifies this problem as being a (continued on next page)

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential for problems. The only area checked for existing pressure injury is to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. No extrinsic factors were identified to include a problem with pressure, sheering, maceration etc. Intrinsic risk factors identified include altered mental status, cognitive loss, incontinence, and poor nutrition. Medications that increase risk for pressure injuries include antipsychotics, antidepressants, and opioids. Diagnoses that present complications or increase pressure injury risk included diabetes, chronic or end stage renal disease, peripheral vascular disease, other dementia, depression, severe pulmonary disease, and pain. Treatments and other factors that cause complications or increase risk was newly admitted or readmitted . Care plan considerations documented yes, pressure injury/functional status will be addressed in the care plan. The overall objective was improvement and avoid complications. The rationale for care plan decision documented: Resident is a [AGE] year old female with pmhx (primary history) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed nursing assistants. Based on the following above (sic), will continue to care plan. Surveyor noted this is the same impact/rationale documented in other CAAs for R14. This CAA was signed as completed on 12/4/25 by MDSRN-HHH.The CAA for dental care was triggered for R14 due to the MDS being checked for R14 having an obvious or likely cavity or broken natural teeth. This is identified as a potential problem for R14. There is no documented nature of the problem or condition on the CAA for R14. Cognitive problems that contributed to oral/dental problems checked cognitive deficit. No functional impairment limiting ability to perform personal hygiene was identified. The section for dry mouth causing buildup or oral bacteria documented medications: antipsychotics, antidepressants, diuretics, opioids, and anticonvulsants. Diseases and conditions that may be related to poor oral hygiene documented unstable diabetes related to oral infection. The section for input from R14, family members or representative was blank. Will dental care-functional status be addressed in the care plan? Yes. The overall objective is documented as avoid complications. The impact of the problem and rational for care plan decision documented R14's Care Area Assessment (CAA) triggered for pressure injury dated 12/4/25 indicates the pressure injury CAA was triggered due to R14 having bowel and bladder incontinence, being at risk for pressure injuries with a stage 2 pressure injury, and R14's assessed need for mobility assistance in bed requiring substantial assistance and being dependent upon staff to lie down and sit up. Analysis of findings identifies this problem as being a potential for problems. The only area checked for existing pressure injury is to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. No extrinsic factors were identified to include a problem with pressure, sheering, maceration etc. Intrinsic risk factors identified include altered mental status, cognitive loss, incontinence, and poor nutrition. Medications that increase risk for pressure injuries include antipsychotics, antidepressants, and opioids. Diagnoses that present complications or increase pressure injury risk included diabetes, chronic or end stage renal disease, peripheral vascular disease, other dementia, depression, severe pulmonary disease, and pain. Treatments and other factors that cause complications or increase risk was newly admitted or readmitted . Care plan considerations documented yes, pressure injury/functional status will be addressed in the care plan. The overall objective was improvement and avoid complications. The rationale for care plan decision documented: Resident is a [AGE] year old female with pmhx (primary history) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed (continued on next page)

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing assistants. Based on the following above (sic), will continue to care plan. This continued to be the same documented summary for other CAAs without providing rational of factors impacting R14's oral hygiene deficits to meet the objective of avoiding complications. This CAA was signed as completed on 12/4/25 by MDSRN-HHH.The CAA for psychotropic drug use was triggered for R14 dated 12/4/25. The triggering conditions were identified as R14 taking antipsychotic medication in the last 7 days or since admission - high risk drug - antipsychotic is documented as yes and R14 was administered an antidepressant in the last 7 days or since admission - high risk drug - antidepressant. This is identified as a potential problem/need for R14. The section for documenting nature of this problem/condition was blank. Classes of medication the resident is taking checked antipsychotic, antidepressant, and sedative/hypnotic. The section for documenting unnecessary medication evaluation is blank. Treatable/reversible reasons for the use of psychotropic medication indicated treatable medical conditions such as heart disease, diabetes, or respiratory disease. Adverse consequences of antidepressant use exhibited by this resident documented anxiety, increased risk for falls, postural hypotension, nervousness, fidgety or restless, and seizures. Adverse consequences of antipsychotics exhibited by this resident documented orthostatic hypotension and falls. Adverse consequences of anxiolytics exhibited by this resident documented sedation manifested by short-term memory loss, decline in cognitive abilities, slurred speech, drowsiness, little/no activity involvement, and depression. Adverse consequences of sedative/hypnotics exhibited by the resident documented mental depression, hypotension, and falls. Medication related discomfort requiring treatment and/or prevention is blank as is the section for overall status change for relationship to psychotropic drug use. The section for input from R14, family members or representative was blank. Will psychotropic drug use-functional status be addressed in the care plan? Yes. The overall objective was identified as improvement. R14's Care Area Assessment (CAA) triggered for pressure injury dated 12/4/25 indicates the pressure injury CAA was triggered due to R14 having bowel and bladder incontinence, being at risk for pressure injuries with a stage 2 pressure injury, and R14's assessed need for mobility assistance in bed requiring substantial assistance and being dependent upon staff to lie down and sit up. Analysis of findings identifies this problem as being a potential for problems. The only area checked for existing pressure injury is to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. No extrinsic factors were identified to include a problem with pressure, sheering, maceration etc. Intrinsic risk factors identified include altered mental status, cognitive loss, incontinence, and poor nutrition. Medications that increase risk for pressure injuries include antipsychotics, antidepressants, and opioids. Diagnoses that present complications or increase pressure injury risk included diabetes, chronic or end stage renal disease, peripheral vascular disease, other dementia, depression, severe pulmonary disease, and pain. Treatments and other factors that cause complications or increase risk was newly admitted or readmitted . Care plan considerations documented yes, pressure injury/functional status will be addressed in the care plan. The overall objective was improvement and avoid complications. The rationale for care plan decision documented: Resident is a [AGE] year old female with pmhx (primary history) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed nursing assistants. Based on the following above (sic), will continue to care plan. Surveyor noted this is the same statement/documented rationale for other CAA areas. This CAA was signed as completed on 12/4/25 by MDSRN-HHH.On 5/7/25 at 3:45 PM Surveyor interviewed MDSRN-GGG and MDSRN-HHH together. Surveyor asked MDSRN-HHH and MDSRN-GGG how they obtain their information to complete an MDS. Both MDSRN-HHH and GGG indicated they review the resident's medical record, ask questions, and if needed go out and assess the resident themselves. MDSRN-HHH (continued on next page)

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and GGG explained what sections of the MDS are completed by social services, activity staff, the dietitian and nursing. Surveyor asked MDSRN's HHH and GGG about what it meant when R14 was assessed on the MDS to be dependent upon staff for ADLs and/or mobility including bed mobility and how it is determined how many staff were needed to assist R14. MDSRN-HHH shared to code dependence on the MDS it does not matter how many staff are needed a resident who is dependent is dependent no matter how many staff. Surveyor asked how is it determined, for example on a care plan whether a resident needed the assistance of 1 or 2 staff as part of their dependence on staff. MDSRN's HHH and GGG stated that is determined by other staff, indicating that may be decided by therapy, sharing a slip is provided saying how many staff are needed. Surveyor asked about the care planning process and how it relates to the CAAs. MDSRN-HHH stated care plans are completed by the nurse managers. Surveyor asked about the process to complete a significant change MDS. MDSRN-GGG shared R14 had declined in areas on their 12/3/25 comprehensive MDS but a significant change MDS was not completed because R14 did not return to the facility, and the facility was still in the 14 day window to decide if a significant change MDS was going to be needed. Surveyor asked MDSRN's HHH and GGG about what they do when the note a decline in a resident's status on the MDS. They indicated they may communicate with therapy or text a nurse if they noticed something. Surveyor asked MDSRN's HHH and GGG how the CAAs are completed and what information is considered. Both indicated they look at the CAAs to see what is triggered and then review the boxes that are checked on the summary and identify interventions to prevent decline or improve a resident's status. Surveyor asked about CAAs that do not have a rationale documented or the rationale summary is not specific to the actual CAA being reviewed. MDSRN-HHH stated, for example, the Dietitian may not document a rational or summary but has a good nutrition assessment in a resident's record. Surveyor asked MDSRN's HHH and GGG if the MDS information, CAA rationales, and other details that may be relevant to developing or modifying a care plan is communicated and discussed as part of team or passed on to nursing or other disciplines making the care plans. MDSRN-HHH shared that by time the CAAs and the MDS are completed there better already be a plan of care in place. It was indicated the assessment details from the MDS are not shared to have a collaborative assessment process that helps establish a plan of care to meet individual resident needs like R14.No additional information was provided.

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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 2 (R11 and R14) of 16 sampled residents had their care plan reviewed and revised by the interdisciplinary team. *R11 experienced falls on 2/13/2026 and 2/14/2026. The facility did not review, revise or update R11's care plan with person centered interventions to prevent additional falls. *R14's Annual Minimum Data Set, dated [DATE] assessed R14 as having a decline in mobility and bladder incontinence. R14's plan of care was not updated to address the change in assistance needed by R14. Additionally, R14's care plan for skin integrity and Activities of daily living were not updated to reflect an individualized plan to reposition R14 despite nursing notes referencing repositioning R14 every 2 hours per protocol. R14 had an unstageable pressure injury with osteomyelitis. Findings include: The facility policy and procedure for comprehensive Care plans implemented 2/5/25, revised 5/1/25 documented for care plans: . Explanation and compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs . 3. The comprehensive care plan will describe, at a minimum, the following: . f. Resident specific interventions the reflects the resident's needs, preferences . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 1.) R11 was admitted to the facility on [DATE] with diagnoses including history of Subarachnoid Hemorrhage and aneurysm, (Status post clipping on12/2025), chronic foley catheter, intrabdominal drain, hemiplegia (severe or total paralysis on one side of the body caused by brain or spinal cord damage), hemiparesis (one-sided muscle weakness) and muscle weakness. R11's admission Minimum Data Set (MDS), dated [DATE], documents that R11 was assessed as having severely impaired cognition, impairment on one side of upper and lower extremities, is dependent on staff for all Activities of Daily Living (ADL)'s and is dependent on staff to roll left to right. The MDS documents no history of falls and no Care Area Assessments (CAA) for falls was triggered. R11's admission Fall risk assessment dated [DATE], documents that R11 is a low fall risk. R11's readmission Fall risk assessment on 2/5/2026, documents that R11 is a moderate fall risk. R11's Fall risk Care plan, initiated 1/16/2026, documents: - be sure R11's call light is within reach and encourage R11 to use it for assistance as needed. R11 needs prompt response to all requests for assistance (continued on next page)

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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Follow facility protocol. The Facility provided document, titled Visual/Bedside Kardex Report for R11, which documents: R11is an assist of 1 staff to turn and reposition, toileting. Ensure call light within reach and a mechanical lift for transfers with 2 staff assistance. Surveyor reviewed R11's Electronic Health Record (EHR) and noted R11 experienced a fall on 2/13/2026 and 2/14/2026. Surveyor noted that R11's care plan was not updated or revised after either fall (cross reference with F689). On 4/16/2026, at 9:02 AM, Surveyor interviewed RN/PM Supervisor-D. RN/PM Supervisor-D informed Surveyor that an RN will perform the assessment of the resident after a fall and put what happened into a progress note, complete the fall packet and implement immediate interventions. The unit manager the next day will review the fall packet and ensure immediate interventions are implemented and care plan reviewed/revised. The Intradisciplinary Team (IDT) will review the fall investigation the next day during morning meetings, but indicated RN/PM Supervisor-D is not part of the morning IDT meetings. On 4/20/2026, at 10:15 AM, Surveyor interviewed Unit Manager (UM)-E. UM-E indicated R11 did not have fall investigations completed and that fall packets are now completed by the floor nurse assigned to the resident who also implements an immediate intervention, the unit managers will review the fall packets and bring to morning meetings for IDT review to ensure care plan review and revisions. On 4/20/2026, at 10:54 AM, Surveyor informed the facility of the above concerns. Nursing Home Administrator- A and Director of Nursing-B informed Surveyor that the facility is working on correcting the process to ensure care plan review/revisions. No additional information was provided. 2.) R14 was readmitted to the facility on [DATE]. R14's Quarterly Minimum Data Set (MDS) with an assessment reference date of 9/3/25 assessed R14 as understanding others and being able to be understood. Staff completed the cognitive assessment interview for R14 with a summary score of 03 indicating severe cognitive impairment. Staff also competed the summary score for mood and behavior for R14 indicating a severity score of 10 for trouble with sleep, feeling tired or with little energy, trouble concentrating, moving slowly or being fidgety (not specified), and being short tempered or easily annoyed. R14 was not assessed to reject care. R14 was assessed as having no functional limitations in range or motion to upper or lower extremities and R14 utilized a wheelchair. R14 is assessed to need set-up assistance for eating and was dependent upon staff for all other activities of daily living (ADLs) except oral hygiene. R14 was assessed to need partial/moderate assistance to roll left and right and substantial to moderate assistance to go from a sit to lying position. All other mobility assessment areas were indicated as not applicable to R14. R14 was assessed to be occasionally incontinent of bladder and always incontinent of bowel and R14 was not on a toileting program. R14 was assessed as not having a swallowing disorder and had experienced weight loss while not being on a physician prescribed weight loss program. R14 was assessed as not being in pain during the assessment period. R14 was assessed to be at risk for pressure injuries with no pressure injuries at the time of the assessment. R14's treatments identified in the MDS included nutrition or hydration intervention to manage skin problems. Treatments to include pressure reducing device for chair or bed were not assessed nor was a turning or repositioning program. (continued on next page)

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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's Annual Minimum Data Set (MDS) assessment with an assessment reference date of 12/3/25 assessed R14 as understanding others and being able to be understood. Staff completed the cognitive assessment interview for R14 with a summary score of 03 indicating severe cognitive impairment. Staff also competed the summary score for mood and behavior for R14 indicating a severity score of 04 indicating R14 had trouble concentrating on things and moving slowly or being fidgety (not specified). No hallucinations or delusions were noted during the assessment or altered mental status. R14 did not demonstrate behaviors to include rejected of care. R14 was assessed as having no functional limitations in range or motion to upper or lower extremities and R14 utilized a wheelchair. R14 is assessed to need set-up assistance for eating and was dependent upon staff for all other activities of daily living now including oral hygiene. R14 was assessed as now needing substantial/maximal assistance for rolling in bed and was assessed as now being dependent upon staff for all other mobility with the exceptions of transferring to tub/shower and walking 10 feet which were assessed as not attempted due to medical condition or safety concerns. R14 was assessed as having a decline in bladder incontinence with a decline from occasionally incontinent to always incontinent. No toileting program is indicated for R14. R14 was assessed as having occasional pain that rarely interferes with day to day activities with a pain intensity rating of 04. R14 is assessed as having no swallowing disorder and no further weight loss. R14 is assessed as being at risk for pressure injuries and had 1 unhealed, stage 2 pressure injury R14 is assessed as having 3 venous or arterial wounds. R14's assessed treatments included nutrition or hydration program to manage skin problems, pressure injury care, application of nonsurgical dressings other than to feet, and application of ointments/medications other than to feet. R14 is not assessed as needing pressure reducing device for chair or bed and for needing a turning and repositioning program. R14's Care Area Assessment (CAA) triggered for pressure injury dated 12/4/25 indicates the pressure injury CAA was triggered due to R14 having bowel and bladder incontinence, being at risk for pressure injuries with a stage 2 pressure injury, and R14's assessed need for mobility assistance in bed requiring substantial assistance and being dependent upon staff to lie down and sit up. Analysis of findings identifies this problem as being a potential for problems. The only area checked for existing pressure injury is to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. No extrinsic factors were identified to include a problem with pressure, sheering, maceration etc. Intrinsic risk factors identified include altered mental status, cognitive loss, incontinence, and poor nutrition. Medications that increase risk for pressure injuries include antipsychotics, antidepressants, and opioids. Diagnoses that present complications or increase pressure injury risk included diabetes, chronic or end stage renal disease, peripheral vascular disease, other dementia, depression, severe pulmonary disease, and pain. Treatments and other factors that cause complications or increase risk was newly admitted or readmitted . Care plan considerations documented yes, pressure injury/functional status will be addressed in the care plan. The overall objective was improvement and avoid complications. The rationale for care plan decision documented: Resident is a [AGE] year old female with pmhx (primary history) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed nursing assistants. Based on the following above (sic), will continue to care plan. R14's Plan of Care (POC) for Impaired skin integrity initiated: 9/2/25; with a created date of 12/18/25 by Wound Registered Nurse (WRN) -L identified the focus as: Left 1st MTH (metatarsal head) arterial ulcer; right 1st MTH arterial ulcer; coccyx unstageable pressure injury; right coccyx unstageable (continued on next page)

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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injury;The Goal is to not experience complications from skin condition requiring hospitalization until wounds are resolved. Target Date: 2/28/26. Interventions identified for R14 included: Surveyor noted all identified interventions have a created date of 12/18/25 by WRN-L. - 9/2/25 Address pain prior to treatment to improve resident tolerance acceptance of wound care.- 12/15/25 Assist resident to shift weight while up in chair at least once an hour.- 9/2/25 nursing to monitor dressing integrity with each resident encounter and replaced dressing if soiled/ loose/ missing. Dressing location (sic): right 1st MTH, coccyx. - 9/2/25 Referral to Registered Dietitian for evaluation related to impaired nutrition impacting wound healing period provide supplements per MD /NP (Medical Doctor/Nurse Practitioner) orders.- 9/2/25 Studies/labs to be performed as needed for diagnostics per MD/ NP orders.- 9/2/25 Wound measurement is performed weekly and PRN (as needed) by Wound Care Team. If resident is unavailable, assessment will be completed at earliest availability.9/2/25 Wound care treatment to be performed by Wound Care Team/ nursing as ordered by MD/NP. R14's care plan for ADL self-care performance deficit r/t (related to) metabolic encephalopathy. was initiated 11/27/24, revised 12/5/24. The Goal is to improve current level of functioning through the review date initiated 5/2/25, revised 12/3/25 with a target date of 12/2/25 (prior to the last revised date). Interventions included were: - 4/15/25 (R14) is weight bearing as tolerated. Revised 4/15/25 - 3/16/25 enabler/assistive device placed bilaterally to improve mobility and increase independence and safety. Revised 10/31/25 - 11/27/24 Bed Mobility: requires minimal assist with bed mobility. Revised 4/15/25 - 11/27/24 Toilet use: is dependent/Hoyer/2 assist for toilet use. Revised 5/5/25. -11/27/24 Transfer: requires Hoyer and two assist for transfers. Revised 5/5/25. Surveyor noted R14's 12/3/25 MDS assessed R14 as having a possible decline in mobility, including rolling from side to side in bed. R14 was assessed as now being dependent upon staff for mobility in bed. R14's care plan was not revised to address R14 requiring additional assistance for bed mobility. R14 also had a care plan for at risk for further impaired skin integrity related to: age, DM11 (diabetes mellitus), sepsis.This care plan identifies historical wound areas for R14. The goal was to not develop further skin impairments initiated 5/2/25 revised 12/18/25 with a target date of 2/28/26. Interventions included: - 11/27/24 assist to turn and/or reposition every 2-3 hours (not individualized). - 11/27/24 Barrier cream with incontinence episode and as needed. (continued on next page)

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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/27/24 Braden upon admission, weekly times 4 weeks, quarterly, and as needed. - 11/27/24 Educate resident/family/caregivers of causative factors and measures to prevent skin injury. - 11/27/24 Encourage good nutrition and hydration in order to promote healthier skin. - 11/27/24 Float heels if resident cannot turn and reposition themselves. Utilize pillows for offloading d/t abnormal positioning of feet. Revised 12/18/25. - 11/26/25 Follow facility protocols for treatment of injury. - 11/27/24 Keep skin clean and dry. Lotion skin with cares. Do not apply lotion between toes. Revised 12/6/24 - 11/27/24 – Monitor skin during cares. Report any changes to nurse. - 11/27/24 Obtain blood work such as CBC (complete blood count) with Diff (differential), blood cultures, and C&S (cultures & sensitivity) of any open wounds as ordered by physician. - 11/27/24 Weekly licensed nurse skin evaluation. On 12/15/25 R14 was observed by nursing staff to have two pressure injuries on their coccyx. These areas were not assessed until 12/18/26. On 12/22/26 R14 had x-rays completed indicating R14 has possible osteomyelitis in their coccyx pressure injury. R14's care plan for at risk for further impaired skin integrity related to: age, DM11 (diabetes mellitus), sepsis.This care plan identifies historical wound areas for R14. The goal was to not develop further skin impairments initiated 5/2/25 revised 12/18/25 with a target date of 2/28/26. Interventions updated 12/18/25 included: - 11/27/24 Pressure reduction mattress. Alternating pressure air mattress. Revised 12/18/25. - 11/27/24 The resident needs pressure reducing cushion to protect the skin while up in wheelchair. Specialty cushion – Vicair. Revised 12/18/25. Surveyor noted these intervention were after R14 developed the two facility acquired coccyx pressure injuries despite R14 being at risk for pressure injuries prior to the development of these areas. Surveyor noted a nursing progress note dated 12/21/25 at 18:02 (6:02 PM) documented: (R14) stayed in bed throughout the weekend due to increased pain from coccyx wound. She was repositioned from side to side q (every) 2 hours. Resident was given assistance in eating to encourage adequate intake. Surveyor noted a specific, individualized repositioning plan of care was not added to R14's skin integrity care plans. R14's Annual MDS dated [DATE] assessed R23 as having a decline in bladder incontinence during the look back period. R14 was assessed as always being incontinent. R14's care plan for incontinence documented: Focus: has (urge, stress, functional, mixed) (this is not specified for R14) bladder incontinence r/t mobility, age. Is at risk for UTI (urinary tract infection) date initiated 11/27/24, created 11/27/24, revised on 8/5/25. Goal documented: will remain free from skin breakdown due to brief use through the review date initiated: 5/2/25, created 11/27/24, revised on 12/3/25, revised on (continued on next page)

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	05/07/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/2/25. Interventions included: 11/27/24 – Clean peri-area with each incontinence episode 11/27/24 – monitor/document for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of color, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. 8/5/25 – UTI infection treatment for 8/5/25. Revised 8/5/25. Review of R14's bladder incontinence care plan indicated it was not updated to identify the type of incontinence R14 has. What a possible voiding pattern may be for R14 and the frequency R14 is to be toileted or check and changed. R14's incontinence care plan was not individualized for R14 despite concerns regarding potential for UTIs and skin breakdown. On 5/7/26 at approximately 8:30 AM Surveyor interviewed Nurse Manager-E regarding the development of care plans for residents. Nurse Manager-E shared that nurse managers are responsible for most of the care plans for residents except those completed by social services, the Dietitian, etc. Surveyor asked if the care plans are reviewed and revised with changes in a resident's status. Nurse Manager shared they should be. Surveyor asked if there is collaboration or information provided by the MDS nurses to ensure the care plans address the assessment for a resident. Nurse Manager-E indicated she has not seen that time of meeting or information being shared. On 5/7/26 at 3:45 PM Surveyor met with MDS Registered Nurses (MDSRN)-GGG and HHH. Surveyor asked about their involvement in the care plan process and how it related to the completion of the MDS. MDSRN-HHH shared that by time the full MDS is finished, especially an annual that requires completion of CAAs, the care plans have been already in place. MDSRN-HHH and GGG stated if the resident is newly admitted they would already have a baseline care plan. Surveyor asked if MDSRN-HHH or MDSRN-GGG participated in a care plan meeting or provide updates to the nurses when there is change in a resident's status on the MDS. Both MDSRN-HHH and GGG indicated no; nurse managers oversee the care plan process.

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	05/07/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not always ensure that 1 (R32) of 4 sampled residents reviewed for ADL (activities of daily living) dependent care received the necessary services to maintain good hand hygiene.R32 is dependent on staff for all activities of daily living. R32 also has significant hand contractures to both the right and left hand. The facility did not ensure that R32 was receiving proper hand hygiene by making sure the length of R32's fingernails would not compromise the skin integrity of the palm of her hand. R32 developed a Stage 3 pressure injury to R32's palm due to her finger nail becoming imbedded into the palm of her left hand. Findings include:R32 was admitted to the facility on [DATE] with diagnosis that included Parkinson's Disease, Contracture of muscle, multiple sites, Muscle Weakness, Contracture of left and right hand and Dementia.R32's Significant Change MDS (Minimum Data Set), dated 1/26/26 documents that R32 has a BIMS (brief interview for mental status) of 8, indicating moderate cognitive impairment. The MDS assesses R32 to have impairments in range of motion on both sides of R32's upper and lower extremities. The MDS documents that R32 was assessed to be fully dependent on staff for all activities of daily living. R32's ADL self-care performance deficit due to Parkinson's and Dementia care plan dated as initiated: 6/27/2025 documents:Interventions included:Bathing/ showering: R32 requires one assist with bathing. Date initiated: 6/27/25.Personal hygiene: R32 is total care. Date initiated: 6/27/25.R32 has impaired skin integrity, as evidenced by: Pressure wounds to Sacrum , Left palm, Left buttocks and left 5th MTH care plan dated as revised on: 04/20/2026 which documents:Interventions included: Apply dry protective gauze to left palm daily and PRN(as needed) for protection/preventative. Date Initiated: 03/16/2026. comfort carrots to both hands. Date Initiated: 04/20/2026 Keep fingernails short (family would like to cut nails themself). Date Initiated: 03/10/2026Surveyor requested to review the weekly shower sheets for R32 that are completed and signed off by the Certified Nursing Assistant completing the shower/ bath and the Nurse who is conducting the weekly skin check. The following was documented:3/5/26- R32 received a bed bath, hair was washed. Fingernails cut- left blank.3/12/26- R32 received a bed bath, hair washed. Fingernails cut- left blank.3/19/26- R32 received a bed bath and hair washed. Fingernails cut- yes.3/26/26- R32 received a bed bath and hair washed. Fingernails cut- yes.4/2/26- R32 received a bed bath and hair washed. Fingernails cut- left blank.4/9/26- R32 received a bed bath and hair washed. Fingernails cut- left blank.4/16/26- R32 received a bed bath and hair washed. Fingernails cut- left blank.4/23/26- R32 received a bed bath and hair washed. Fingernails cut- left blank. The body chart has documentation cut nail on left hand.4/30/26- R32 received a bed bath and hair washed. Fingernails cut- left blank. The body chart has documentation had cut on left hand. R32's Occupational Therapy Note, dated 4/20/26 and written by Occupational Therapist-ZZ documents: R32 seen to facilitate increased tolerance to wearing progressive orthotic (carrot splint) to increase space between fingers and palm due to right and [NAME] contracture. However, upon visit this date, R32 was noted to have a wound on her left palm due to length of fingernails and contracture, therefore not donning carrot in left hand. Placed gauze in left hand and notified nursing staff and wound care nurse this date.R32's nursing note dated 4/20/2026 at 12:19 PM documents: Writer was notified by therapist (Occupational Therapist- ZZ) that R32 was developing a wound on Left palm. Writer and nurse went in room and did an assessment on hand and noticed that fingernail was embedded in palm. Resident (R32) c/o pain and discomfort during assessment. Therapy opened palm of hand and placed gauze on wound. Nurse assessed, notified provider and wound care team. W/C (wound care) will be placing new treatment for healing.Surveyor reviewed the facility's grievance log and noted that on 4/22/26 a grievance was filed by R32's family. The grievance details included family also reports that they are concerned with R32 receiving proper hygiene due to fingernail care recently being embedded in hand. Summary of findings due to severity of hand contracture, therapy carrot cannot stay in R32's (continued on next page)

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	05/07/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand 24/7. Summary of actions taken, floor staff will maintain R32's fingernail care and hygiene.Surveyor noted that R32's individual plan of care was not updated to reflect that facility staff were to provide nail care to R32. R32's plan of care still listed R32's family as being responsible for R32's nail care. On 5/5/26 at 10:14 AM, Surveyor interviewed Occupational Therapist (OT)- ZZ regarding R32 receiving therapy services due to the severe contractures of her right and left hands. OT-ZZ informed Surveyor that on 4/20/26, OT- ZZ was working with R32 when noted that on the left hand, R32's nails were embedded into the skin. OT- ZZ could not recall if it was 1 or 2 fingernails. OT-ZZ stated that he slowly tried to take the fingernail(s) out of the skin and then place gauze in R32's palm of her hand. OT- ZZ confirmed that there was not gauze in place at the time he observed the embedded fingernail(s). OT-ZZ stated there was a lot of moisture in R32's palm and R32 complained of pain. OT- ZZ stated that on 4/20/26, R32's nails were long and it would really take a professional to address cutting the nails due to the significance of the hand contracture. OT- ZZ stated that an order for nail care would need to come from nursing. On 5/5/26, during the daily exit, Surveyor informed Nursing Home Administrator- A and DON-B of the above findings. As of the time of exit, the facility did not provide additional evidence that nail care was provided by staff since 3/26/16 to R32. R32's hand contractures made it necessary that fingernail length was kept short to avoid any further impairment to the function of her hands or skin impairments.

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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 interview and record review, the facility failed to ensure 5 (R14, R5, R31, R12, and R8) of 5 sampled residents received care and treatment in accordance with assessments and professional standards of practice (including N6, Nurse Practice Act) to ensure their highest practicable physical, mental, and psychosocial well-being. Facility staff did not assess changes in condition, did not ensure orders for labs and treatments were promptly implemented, and did not communicate condition changes to appropriate personnel as necessary to ensure consistency and continuity of care across all disciplines. * R14's Annual Minimum Data Set, dated [DATE] assessed R14 as having declines in her incontinence and mobility during the look back time frame. These declines were not further assessed or addressed in R14's plan of care. On 12/11/25 laboratory results indicated a possible change in condition regarding hydration, kidney function and changing protein levels for R14. The recommendation from Nurse Practitioner (NP)-I was to repeat in 1 week. On 12/22/25 repeat labs were completed on R14. The results of the labs were not reviewed by NP-I until 12/26/25. The results of the labs on 12/22/25 indicated elevated glucose, which was not present on R14's 12/11/25 labs. The labs values noted on 12/11/25 progressively changed. The diagnosis identified on the lab results indicated altered mental status. NP-I did not place any new orders to address R14's progressive change in condition or to monitor R14 for signs and symptoms of dehydration or other possible changes in condition. On 12/23/25 Licensed Practical Nurse (LPN)-EE documented R14 was pocketing food. A diet downgrade slip was submitted to the kitchen changing R14's diet from mechanical soft with regular liquids to pureed with nectar thick liquids. R14 was not assessed for this change in status and an order was not received for this downgrade in consistency for R14. Dietitian-G was not notified that R14 had an infected wound and was having possible diet and nutritional changes to assess. R14's care plan was not revised to ensure R14 received added assistance to ensure safety and adequate intake. On 12/15/25 R15 was noted to have 2 facility acquired pressure injuries (coccyx and right coccyx). R14's pressure injuries were not comprehensively assessed nor were interventions implemented for R14 to prevent further decline in R14's pressure injuries. X-rays on 12/22/25, due to R14's increased expression of pain in her coccyx, indicated R14 could not be ruled out as having osteomyelitis. R14 did not have additional assessments of the possible osteomyelitis and no treatment plan was implemented by NP-I. (Cross-reference F686). On 12/24/26 NP-I documented in her progress notes: She (R14) has a coccyx wound with concerns for osteomyelitis, confirmed on x-ray. Over time, her overall condition has declined further, and she now displays significant difficulty swallowing, as evidenced by her pocketing food . The patient's (POAHC-CCC), who serves as her activated power of attorney, is in agreement with transitioning (R14) to hospice care services to prioritize her comfort moving forward. On 12/25/25 NP-I ordered R14 to receive morphine as needed (PRN) for end of life care. Interview with POAHC-CCC on 4/17/26 at 3:44 PM indicated POAHC-CCC was not made aware of the full extent of R14's changes in condition during the month of December 2025. POAHC-CCC stated at no time did POAHC-CCC agree to or sign documents placing R14 on hospice or agree to end of life care. POAHC-CCC stated the topic was raised by NP-I and a person from a hospice agency but POAHC-CCC had questions whether R14 would even qualify. POAHC-CCC shared she repeatedly asked if R14 had an infection and was told no. On 12/28/25 R14 experienced a change in condition and was sent to the emergency department (ED) (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	where R14 was diagnosed with severe sepsis, acute renal failure and hypovolemic shock; along with notation of having a pressure injury the size of a fist. R14 passed away on 12/29/25. *On 4/5/26, Certified Nursing Assistant (CNA)-X was performing cares alone with R5 in bed, resulting in R5 rolling out of bed. (Cross-reference F689). On 4/6/26 staff indicated awareness of R5 having Bilateral Lower Extremity (BLE) crackling during movement of R5's legs during cares and transfers. This change was not further assessed or communicated with R5's physician. On 4/7/26 R5 was noted to have a left ankle deformity. This was not further assessed, and a consultation was not completed with R5's physician. On 4/9/26, R5 was sent to the Emergency Department (ED) where R5 was diagnosed with bilateral tibia and fibula fractures (bone fractures in the lower legs typically caused by high-energy twisting injuries). R5 was noted to have significant bruises to their body that had not been documented or assessed by facility staff. A forensic assessment was ordered for R5 in the ED due to increased concerns by the hospital R5 had been abused. The facility failed to promptly identify and intervene with acute changes noted on 4/6/26 and 4/7/26. The facility continued to transfer R5 via Hoyer lift and manipulate R5's bilateral lower extremities (BLE) without assessing R5 when it was previously described as staff having to manipulate R5's BLE's due to R5's contractures. The facility failed to perform a Registered Nurse (RN) assessment on 4/6/26, when R5 was noted to have a significant change with staff noting crackling when manipulating R5's BLEs and BLE deformity and increased bruising. * R31 was admitted to the facility on [DATE] for rehabilitation following hospitalization. R31 was receiving diuretics as part of their medication regime. On 4/1/26 the facility received an order from the cardiac clinic to draw labs on R31 on 4/6/26, in preparation for a follow up appointment. On 4/6/26 the cardiac clinic also ordered daily weights to be obtained and recorded for R31 and the implementation of a fluid restriction of 64 fluid ounces. There is no indication the R31 had the lab completed on 4/6/26 as ordered by the cardiac clinic. On 3/30/26 R31 had labs drawn with no corresponding order or detail of who requested the lab draw. There is no indication the facility followed up on any results of the 3/30/26 lab draw that was completed. On 4/8/26 the cardiac clinic contacted the facility asking about the lab results that were to be drawn on 4/6/26. The cardiac clinic was faxed a copy of the 3/30/26 lab results from the facility. The lab results from 3/30/26 indicated R31's potassium level was 2.9 which is an indicator of moderate hypokalemia and requires immediate medical attention. Upon receipt of this lab result, the cardiac clinic contacted the facility and ordered R31 to be emergently transferred to the emergency department (ED). R31 required admission to the hospital for monitoring and stabilization. R31's potassium level was 2.5 upon arrival at the ED. The facility also failed to ensure orders to monitor R31's weight daily and to modify the diuretic R31 was to receive based upon weight was administered as ordered. The facility failed to have a system to ensure labs are ordered, completed, and results of the lab are conveyed and addressed by a physician or practitioner based upon a standard of practice. The facility's failure to provide care to R14, R5, and R31 based upon assessment and professional standards of practices created a finding of immediate jeopardy in the facility starting 12/22/25 based upon example regarding R14. On 4/20/26 at 3:54 PM Surveyors notified Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B and Director of Operations (DOO)-O of the immediate jeopardy regarding care concerns for R14 and R5. On 5/7/26 at 1:30 PM, Surveyors informed Current NHA-AAA, Former NHA/Director of Nursing (DON)-A, DOO-O and Chief Nursing Officer (CNO)-DDD of the additional immediate jeopardy example regarding R31. The Immediate Jeopardy was not removed at F684 upon exit from the facility on 5/7/26. The facility was also cited for concerns regarding R12 and R8. (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	* R12 had a Foley catheter, and a Urology Consult was ordered on 12/8/25 for continued use. There is no documentation this was implemented. * R8 admitted to the facility with a documented right upper extremity skin alteration that was not treated or assessed by the facility. Findings include: The facility's policy and procedure Notification of Changes revised 3/10/2025 documents The Guidelines: The purpose of this guideline is to ensure the facility promptly informs the resident, consults the resident's physician; And notifies, consistent with his or her authority, the resident representative when there is a change requiring notification. Changes of condition require an evaluation by using the e-interact change in condition evaluation ensures proper documentation and notification has been made. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances Requiring Notification Include: 1. Accidents a. resulting in injury b. potential to require physician intervention 2. Significant change in the resonance physical, mental or psychosocial condition such as deterioration and health, mental or psychosocial status. a. Life threatening conditions, or b. Clinical complications c. Critical lab values 3. Circumstances that require a need to alter treatment. This may include; a. New treatment b. Discontinuation of current treatment due to; i. Adverse consequences ii. Acute condition iii. Exacerbation of a chronic condition. (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's policy and procedure Providing End of Life Care revised 12/1/2024 indicates: Policy: The facility is committed to providing the needed care and services to those residents at or approaching end of life care in accordance with the resident's preferences, goals, and professional standards of practice in order to promote their highest practicable physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines: 1. The facility utilizes a systematic approach for recognition, assessment, treatment, and monitoring of end-of-life care. 2. Recognition: a. Residents will be evaluated for end-of-life care concerns upon admission, during scheduled assessments, and upon change of condition status. b. The physician will document the residents' prognosis of a life expectancy of less than 6 months, or a terminal illness. c. The facility, in collaboration with the resident's attending physician/practitioner, will inform and educate the resident and/or the resident's family about decisions for end-of-life care. d. Preferences for palliative care, hospice care, and advanced directives will be identified and documented in the medical record. This includes preferences regarding treatment of acute illness, and choices regarding hospitalization. The facility's policy and procedure Consulting Physician/Practitioner Orders revised 10/4/2024indicates: The Policy: The attending physician shall authenticate orders for the care and treatment of assigned residents. Policy Explanation and Compliance Guidelines: Consulting physician practitioner orders are those orders provided to the facility by a physician/ practitioner other than the residents attending physician/ practitioner who is acting on behalf of the attending physician. A consulting physician/ practitioner may include, but is not limited to, the residents: d. Specialist such as Urologist. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. 1.) R14 was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, seizures (on anticonvulsants), senile dementia, COPD (chronic obstructive pulmonary disease), asthma, AKI (acute kidney disease), anemia, hypothyroidism, hypertension, hyperlipidemia, hypotension, Type II diabetes mellites, chronic pain, smoker, bipolar type 2, paranoid schizophrenia, anxiety, depression, dehydration and Bacteriuria. R14's Annual Minimum Data Set (MDS) assessment with an assessment reference date of 12/3/25 assessed R14 as understanding others and being able to be understood. Staff completed the cognitive assessment interview for R14 with a summary score of 03 indicating severe cognitive impairment. Staff also competed the summary score for mood and behavior for R14 indicating a severity score of 04 indicating R14 had trouble concentrating on things and moving slowly or being fidgety (not specified). No hallucinations or delusions were noted during the assessment or altered mental status. R14 did not demonstrate behaviors to include rejected of care. R14 was assessed as having no functional limitations in range or motion to upper or lower extremities and R14 utilized a wheelchair. R14 is assessed to need set-up assistance for eating and was dependent upon staff for all other activities of daily living now including oral hygiene. R14 was assessed as now needing substantial/maximal assistance for rolling in bed and was assessed as now being dependent upon staff for all other mobility with the exceptions of transferring to tub/shower and walking 10 feet which were assessed as not attempted due to medical condition or safety concerns. R14 was assessed as having a decline in bladder incontinence with a decline from occasionally incontinent to always incontinent. No toileting program is indicated for R14. R14 was assessed as having occasional pain that rarely interferes with day to day activities with a pain intensity rating of 04. R14 is assessed as having no swallowing disorder and no further weight loss. R14 is assessed as being at risk for pressure injuries and had 1 unhealed, stage 2 pressure injury R14 is assessed as having 3 venous or arterial wounds. R14's assessed treatments included nutrition or hydration program to manage skin problems, pressure injury care, application of nonsurgical dressings other than to feet, and application of ointments/medications other than to feet. R14 is not assessed as needing pressure reducing device for chair or bed and for needing a turning and repositioning program. Section J regarding R14's prognosis documents no – indicating R14 does not have a condition or chronic disease that may result in a life expectancy of less than 6 months. R14's Care Area Assessment (CAA) triggered for nutrition dated 12/4/25. Triggering conditions were R14's BMI (body mass index), R14 receiving a mechanically altered diet and the diet is therapeutic as a nutritional approach and R14 has 1 stage 2 pressure injury or higher that is not healed. The analysis of findings indicates this is an actual problem for R14. Nature of problem/condition is documented as triggered r/t (related to) obesity, hx (history of) weight loss but weight stabilizing over the past couple of months, triggers r/t mech soft (mechanical soft consistency)- ground meats due to dysphagia. Triggers r/t Boost supplement use for nutrition support and weight maintenance. No current eating patterns are identified. Functional problems that affect ability to eat is identified as need for special diet or altered consistency which might not appeal to resident. Cognitive, mental (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	status and behavior problems that can interfere with eating indicated other dementia, disruptive behaviors, throwing food, poor memory, and anxiety problems. No communication problems are identified. Dental/oral problems indicated include broken or fractured teeth. Other diseases and conditions that can affect appetite or nutritional needed indicated anemia, cardiovascular disease, depression, pain, thyroid problem, diabetes, and respiratory disease. The CAA does not indicate any abnormal lab values. Medications identified included antipsychotics and diuretics. No environmental factors are documented. The is no input documented from R14 or POAHC-CCC. Care plan considerations documented maintain current level of functioning. Dietitian-FFF did not document a summary or rationale for care plan for R14. (Cross-reference F636). R14's CAA for pressure injury and ADLs were also triggered. LABORATORY CHANGES/MONITORING: On 12/11/25 laboratory results were obtained indicating R14 had low sodium, elevated blood urea nitrogen (BUN), elevated creatinine, elevated GOT/AST (asparate minotransferase), low albumin, low total protein level, elevated globulin levels, and low albumin to globulin (A/G) ratio. The lab results indicated a possible change in condition regarding hydration, kidney function and changing protein levels for R14. The listed diagnosis on the lab report was hyperprolactinemia (CMD – abnormally high levels of prolactin in the blood). The recommendation and documented note from Nurse Practitioner (NP)-I on 12/12/25 was to repeat in 1 week. This was not completed until 10 days later. On 12/22/25 repeat labs were completed on R14. The results of the labs were not reviewed by NP-I until 12/26/25 with NP-I giving no new orders as a result of the labs. The results of the labs on 12/22/25 indicated elevated glucose, which was not present on R14's 12/11/25 labs. The labs values flagged as high or low on 12/11/25 progressively changed. The diagnosis identified on the lab results indicated altered mental status. NP-I did not place any new orders to address R14's progressive change in condition or to monitor R14 for signs and symptoms of dehydration or other possible changes in R14's status. NP-I did not review R14's use of diuretics at this time despite indicators R14 was dehydrated. On 4/16/26, at 12:06 PM, Surveyor interviewed NP-I regarding R14's lab results from 12/11/25 and 12/22/25. Surveyor asked NP-I about the results from the 12/11/25 lab draw and if the results were concerning or indicators of any changes occurring with R14. NP-I indicated she requested repeat labs in a week. Surveyor asked NP-I about the process to obtain and review lab results, noting the lab results were available on 12/22/25 but were not noted and reviewed by NP-I until 12/26/25. NP-I shared the labs are usually pulled and provided to her when she comes into the facility. Surveyor asked NP-I if NP-I had been in the facility between 12/22/25 and 12/26/25 where NP-I could have reviewed the lab results sooner. NP-I shared she was in the facility on 12/23 and 12/24/25. When asked about the delay in reviewing R14's 12/22/25 labs NP-I did not know why they were not provided to her until 12/26/25. Surveyor asked NP-I about any orders or monitoring recommendations given the lab values on 12/22/25. NP-I stated no, she did not order any treatments or recommendations due to R14 receiving hospice and end of life care. PRESSURE INURY DECLINE/CHANGE IN CONDITION: (Cross-reference F686). R14's Nursing Progress Notes dated 12/15/25, written by RN-H, documented: Notified the POAHC (CCC) regarding new order for wounds. (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R14's medical record indicated a comprehensive assessment was not completed on 12/15/25 of the (potentially) 2 new, facility acquired unstageable wounds R14 developed. Review of R14's facility wound assessment forms indicated R14 developed two, unstageable, facility acquired pressure injuries; one on the coccyx and a second on the right coccyx. These were not comprehensively assessed until 12/18/25. Review of R14's treatment administration record (TARs) indicated the treatment was not documented as being completed per the physician order. R14's care plan for at risk for further impaired skin integrity related to: age, DM11 (diabetes mellitus), sepsis.This care plan identifies historical wound areas for R14. The goal was to not develop further skin impairments initiated 5/2/25 revised 12/18/25 with a target date of 2/28/26. Interventions updated 12/18/25 included: - 11/27/24 Pressure reduction mattress. Alternating pressure air mattress. Revised 12/18/25. - 11/27/24 The resident needs pressure reducing cushion to protect the skin while up in wheelchair. Specialty cushion – Vicair. Revised 12/18/25. Surveyor noted these intervention were after R14 developed the two facility acquired coccyx pressure injuries on 12/15/25 and despite R14 being at risk for pressure injuries prior to the development of these areas. A nursing progress note dated 12/21/25 at 18:02 (6:02 PM) documented: (R14) stayed in bed throughout the weekend due to increased pain from coccyx wound. She was repositioned from side to side q (every) 2 hours. Resident was given assistance in eating to encourage adequate intake. Surveyor noted that despite documentation of pain and changes in R14's activity and eating there was no assessment of R14's wounds. The weekend included 12/19, 12/20, and 12/21/25. R14's coccyx Wound assessment dated [DATE] at 10:49 AM by Wound Registered Nurse (WRN)-L documented: measurements of 2.80 cm x 2.30 cm x 2.8 cm with the wound bed having 90% loosely adherent slough and 10% bright pink or red (not specified or further detailed) with moderate serous drainage. The peri-wound was documented as having erythema. There is undermining present between 12 o'clock and 1 o' clock 2 cm and between 5 o'clock and 6 o'clock 2 cm. The picture of the coccyx wound has a date and time stamp of 12/22/25 at 10:46 AM. Pain is documented as 3 on the pain scale. The assessment included documentation of probable improvement despite the increased size of the wound and undermining. Surveyor noted there is no assessment of the right coccyx wound dated 12/22/26. On 12/22/25 at 14:41 (2:41 PM), imagining was performed on R14's coccyx due to pain and wound decline. Reason for the study is documented as osteomyelitis, unspecified. Findings: Question subtle bone loss of the dorsal aspect of the sacrum/coccyx. Soft tissues appear swollen with ulceration dorsally. Conclusion: Cannot exclude osteomyelitis, recommend MRI work up. The radiology report included a handwritten note that documented MRI of sacrum coccyx for Dx (diagnosis) osteomyelitis signed as reviewed by NP-I on 12/23/25. Surveyor noted there are no additional orders documented to order and schedule an MRI, potentially obtain a culture and sensitivity of R14's wound, or treatment despite indications R14 had osteomyelitis. Nursing progress notes dated 12/23/25 at 16:32 (4:32 PM) documented: Resident continues to show s/sx (signs/symptoms) of pain r/t coccyx wound, dressing changed d/t soiled with drainage from wound. Surveyor noted that despite documented drainage from R14's pressure injury soiling the dressings R14's pressure is not reassessed and there is no consultation with R14's physician or nurse practitioner despite knowledge R14 has osteomyelitis in their coccyx pressure injury. NP-I's progress note dated 12/23/25 documented: (R14) is seen today due to concerns about the worsening of her wound. An x-ray of her sacral coaxal area was performed, which could not rule out osteomyelitis. (R14) has experienced further decline. She has complex medical history that includes (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	metabolic encephalopathy, COPD, type 2 diabetes, immunodeficiency, peripheral vascular disease, bipolar disorder, dementia and schizophrenia . Assessment: 1. Worsening wound condition: unable to rule out osteomyelitis based on the x-ray, patient experiencing a decline. complex medical history complicates the medical picture. 2. Comprehensive Medical Background: metabolic encephalopathy, COPD, type 2 diabetes; immunodeficiency and peripheral vascular disease, bipolar disorder, dementia, and schizophrenia. Plan: . continue in-house wound care with nursing staff support to monitor (R14's) comfort. NP-I's progress note dated 12/24/25 documented: (R14) was seen today for a follow up regarding her long-term care goals. She has a coccyx wound with concerns for osteomyelitis, confirmed on x-ray. Over time, her overall condition has declined further. Physical exam: Patient is stable and in no acute distress. Diagnostic test results: X-ray findings support concerns for osteomyelitis in the coccyx. Assessment: 1. Coccyx wound with concerns for osteomyelitis, contributing to ongoing wound management challenges. 3. Declining overall condition: The patient continues to experience progressive clinical decline, necessitating a shift in care goals towards comfort and end-of-life services. Plan: 1. Coccyx wound with concerns for osteomyelitis: maintain in-house wound care management, ensure continued attention to wound healing and prevention of further complications. Surveyor noted R14's pressure injury(ies) were avoidable, facility acquired pressure injury (ies) that were not appropriately prevented, assessed, and treated based on standards of practice to prevent further decline and complications. Cross reference F686, Nursing notes dated 12/25/25 at 06:46 AM documented Resident turned q2 hours per protocol in place. Tx to coccyx wound C/D/I (clean/dry/intact). No c/o (complaints of) pain or discomfort noted this shift. All medications taken (sic) and tolerated well. Continue current POC. No revisions were documented on R14's POC to ensure staff consistently followed a repositioning schedule for R14. On 12/26/25 a nurse's progress note documented by NP-I documented lab results reviewed with no new orders. (Reference above section). On 12/26/25 at 10:43 AM NP-I ordered Morphine Sulfate 0.5 ml (milliliter) by mouth every 2 hours as needed for pain, SOB (shortness of breath), elevated heart rate, end of life care. This order triggered drug to drug interaction warnings for R14. A nurse's note dated 12/26/25 at 11:26 AM noted the new order for morphine PRN q 2 hours. R14's Medication Administration Record (MAR) December 2025 documents that R14 received morphine sulfate on12/26/25 due to R14 having pain in their coccyx. On 4/16/26, at 12:06 PM, Surveyor interviewed NP-I. NP-I stated they could not remember if they were notified of R14's pressure injuries on 12/15/25. NP-I shared they were made aware of R14 having increased pain in their coccyx wound and ordered imagining. The x-ray results came back on 12/22/25 showing osteomyelitis. Surveyor asked NP-I if NP-I observed or assessed R14's pressure injury(ies). NP-I stated R14's wounds were being addressed by the facility wound team. Surveyor asked NP-I if NP-I was aware of the delayed assessments of R14's pressure injury(ies) and lack of individualized interventions to prevent and help heal R14's pressure injuries. NP-I indicated she was not aware, that it was handled by the facility wound team. Surveyor asked NP-I about the x-ray results indicating R14 had possible osteomyelitis and recommendations/orders from NP-I to address and treat R14's osteomyelitis. NP-I shared they did not order any treatment for the wound infection. (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	NUTRITION/ POTENTIAL SWALLOWING DECLINE On 12/11/25 and 12/22/25 R14 had results from a Comprehensive Metabolic Panel (CMP). The results for the 12/22/25 lab were not noted or reviewed by NP-I until 12/26/25. The 12/22/25 labs were drawn as follow up/repeat to the labs originally drawn on 12/11/25. Review of R14's medical record indicated R14 was at risk for dehydration and metabolic encephalopathy along having a history of urinary tract infections going back to September 1, 2025 when R14 was readmitted to the facility following hospitalization. Review of R14's care plans indicated: R14's Certified Nursing Assistant (CNA) Kardex (plan of care) does not document any swallowing guidelines or care plan to monitor R14's fluid intake. R14's Dehydration Care Plan documented: The resident has potential fluid deficit r/t (related to) hx (history of) dehydration AEB (as evidenced by) IVF (intravenous fluid) given in the hospital – initiated/created 12/9/24, revised 12/2/25. Goal: the resident will drink/take in a minimum of (not specified) cc's each 24-hour period – initiated/created 12/2/25, revised 12/2/25, Target date: 9/2/25 (sic). Intervention documented: - Educate the resident/family/caregivers on importance of fluid intake – initiated/created 12/9/24, revised 12/2/25 - Monitor/document/report PRN any s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes – initiated 12/9/24, revised 12/2/25 R14's Nutrition Care plan documented: The resident is at risk for nutritional imbalance r/t obesity r/t good intakes, sedentary lifestyle aeb(as evidenced by) Body Mass Index (BMI) > (greater than) 30, need for mech (mechanically) altered diet d/t dysphagia aeb mech (mechanical) soft diet, potential for wt (weight) flux due to fluid shifts, impaired skin – unst (unstageable) PI (pressure injury) – coccyx x (times) 2; vascular – L (left) 1st MTH (metatarsal head), R (right) 1st MTH(right big toe) – initiated 12/2/25, created 12/9/24, revised 12/22/25. Goal: The resident will not develop complications related to obesity, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date. Initiated 5/2/25, created 12/9/24, revised 12/10/25, Target date: 3/10/26. Goal: The resident will maintain adequate nutritional status as evidenced by no sig wt (significant weight) changes or gradual weight loss, no s/sx (signs/symptoms) of malnutrition, and consuming >75% est (estimated) nutritional needs through review date. Initiated 5/2/25, created 12/9/24, revised 12/10/25. Target date 3/10/26. - Administer medications as ordered. Monitor/document for side effects and effectiveness. Initiated/created 3/3/25 (continued on next page)

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	05/07/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	- Monitor/document/report PRN (as needed) any s/sx of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals – initiated/created 12/9/24 - Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated – initiated/created 3/3/25 - Offer PM (nighttime) snack – yogurt – initiated/created 11/19/25 On 12/22/25 at 16:08 4:08 PM) a nutrition/dietary note was completed by Dietitian-G that documented: F/U (follow up) skin. Per wound assessment 12/22, unstageable PI – coccyx & laceration – vascular. Per wound assessment 12/18, unstageable PI-R (right) coccyx. PIs are new. Has hx (history) of PIs that had healed; however, these are new. Receives regular – mech (mechanical) soft diet which is

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure 3 (R14, R15 and R32) of 3 sampled residents with pressure injuries received care and treatment based upon standards of practice to promote healing, prevent infection, and prevent new pressure injuries from developing. * R14 was assessed to be at risk for pressure injuries and was noted to have a pressure injury that was healed on 12/1/25. 12/3/25 was the assessment reference date for R14's annual minimum data set (MDS). This MDS assessed R14 as requiring greater assistance for turning and repositioning and decline in incontinence of bladder for R14. This MDS also identified R14 to be at risk for pressure injuries but did not assess additional interventions such as pressure relieving devices for R14's wheelchair and bed and a repositioning program for R14 as her mobility had declined. On 12/15/25 R14 was noted to have 2 facility acquired, avoidable unstageable pressure injuries located on R14's coccyx and buttock. These areas were not comprehensively assessed upon discovery. Revisions were not made to R14's plan of care to address R14's changes in status or to prevent further decline in the wounds. During the period of time following the discovery of the wounds to 12/22/25 R14 expressed feeling pain in her coccyx/buttock area. On 12/22/26 an x-ray result indicated the possible presence of osteomyelitis in R14's pressure injury(ies). This determination of possible osteomyelitis was not further assessed or treated by the facility; specifically, by Nurse Practitioner (NP)-I. R14's Power of Attorney for Healthcare (POAHC)-CCC was not provided with timely and accurate information regarding R14's pressure injuries to make an informed decision regarding R14's overall care. On 12/28/25 R14 was transferred to the hospital for a progressive change in condition that included infection. The Hospital Emergency Department (ED) Notes dated 12/28/25 documented a necrotic sacral ulcer the size of a fist. The facility's failure to assess and treat R14's possible osteomyelitis created a situation of immediate jeopardy that began on 12/22/25. Surveyor notified the Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B and Director of Operations (DOO) -O, of the immediate jeopardy on 4/20/26 at 4:30 PM. The immediate jeopardy was removed on 5/7/26, however, the deficient practice continues at a scope and severity of G (actual harm/pattern) as the facility implements its action plan and related to the following examples regarding R15 and R32: *R15 admitted to the facility at risk for pressure injuries, with no current pressure injuries. R15 was dependent on staff for cares including bed mobility and repositioning. R15 developed an avoidable, unstageable pressure injury to the left elbow on 3/10/26. The facility did have preventative measures in place prior to R15 developing the pressure injury and did not immediately put pressure relieving interventions into place after finding the pressure injury. Interventions were not added to R15's plan of care until 3/18/26. During the survey, R15 was observed to not have pressure relieving interventions in place per their plan of care. * R32 has contractures to both hands. R32 developed an avoidable, facility acquired stage three pressure injury due to R32's fingernails becoming embedded in R32's palm. R32's plan of care was not updated to reflect that facility staff should trim R32's fingernails and R32's pressure injury was not comprehensively assessed when it was first discovered. Findings include: (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy and procedure Pressure Injury Prevention and Management revised 4/17/25 documents: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/ injury, prevent infection and the development of additional pressure ulcer/ injuries. Explanation and Compliance Guidelines:2. The facility shall establish and utilize A systematic approach for pressure injury prevention and management, including prompt assessment and treatment; Intervening to stabilize, reduce or remove underlying risk factors; Monitoring the impact of the interventions; And modifying the interventions as appropriate.4. Assessment of Pressure Injury [NAME]. Licensed nurses will conduct a pressure injury risk assessment, using the Braden Risk Evaluation, and all residents upon admission, weekly times 4 weeks, then quarterly or whenever the residence condition changes significantly.c. Licensed nurses will conduct a full body skin assessment on all residents upon admission readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record.d. Assessments of pressure injuries will be performed by a licensed nurse and documented on the medical record. The staging of pressure injuries will be clearly identified to ensure correct coding on the Minimum Data Set (MDS).4. Interventions for Prevention and Promote Healing.a. After completing A thorough assessment evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions.b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g. Moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).c. Evidence based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present period basic or routine care interventions could include, you're not limited to; I. Redistribute pressure (such as repositioning, protecting and/or offloading heels; II. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; III. Provide appropriate, pressure redistributing, support services; IV. Provide non-irritating surfaces; and V. Maintain or improve nutrition and hydration status, were feasible. 1.) R14 was readmitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, dysphagia (difficulty swallowing) and metabolic encephalopathy. In November of 2025 R14 was diagnosed with peripheral vascular disease. R14's Quarterly Minimum Data Set (MDS) with an assessment reference date of 9/3/25 assessed R14 as understanding others and being able to be understood. Staff completed the cognitive assessment interview for R14 with a summary score of 03 indicating severe cognitive impairment. Staff also completed the summary score for mood and behavior for R14 indicating a severity score of 10 for trouble with sleep, feeling tired or with little energy, trouble concentrating, moving slowly or being fidgety (not specified), and being short tempered or easily annoyed. R14 was not assessed to reject care. R14 was assessed as having no functional limitations in range or motion to upper or lower extremities and R14 utilized a wheelchair. R14 is assessed to need set-up assistance for eating and was dependent upon staff for all other activities of daily living (ADLs) except oral hygiene. R14 was assessed to need partial/moderate assistance to roll left and right and substantial to moderate assistance to go from a sit to lying position. All other mobility assessment areas were indicated as not applicable to R14. R14 was assessed to be occasionally incontinent of bladder and always incontinent of bowel and R14 was not on a toileting program. R14 was assessed as not having a swallowing disorder and had experienced weight loss while not being on a physician prescribed weight loss program. R14 was assessed as not being in pain during the assessment period. R14 was assessed to be at risk for pressure injuries with no pressure injuries at the time of the assessment. R14's treatments identified in the MDS included nutrition or hydration intervention to manage skin problems. Treatments to include pressure reducing device for chair or bed were not assessed nor was (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a turning or repositioning program. By the time of the next assessment, R14's condition had changed. R14 was assessed as now needing substantial/maximal assistance for rolling in bed and was assessed as now being dependent upon staff for all other mobility with the exceptions of transferring to tub/shower and walking 10 feet which were assessed as not attempted due to medical condition or safety concerns. R14 was assessed as having a decline in bladder incontinence with a decline from occasionally incontinent to always incontinent. No toileting program is indicated for R14. R14 was assessed as having occasional pain that rarely interferes with day to day activities with a pain intensity rating of 04. R14 is assessed as being at risk for pressure injuries and had 1 unhealed, stage 2 pressure injury R14 is assessed as having 3 venous or arterial wounds. R14's assessed treatments included nutrition or hydration program to manage skin problems, pressure injury care, application of nonsurgical dressings other than to feet, and application of ointments/medications other than to feet. R14 is not assessed as needing pressure reducing device for chair or bed and for needing a turning and repositioning program. Review of R14's electronic medical record (EMR) indicated R14 had a stage 2 pressure injury to left medial buttock that started on 11/17/25 and was documented as healed on 12/1/25. R14's Care Area Assessment (CAA) triggered for pressure injury dated 12/4/25 indicates the pressure injury CAA was triggered due to R14 having bowel and bladder incontinence, being at risk for pressure injuries with a stage 2 pressure injury, and R14's assessed need for mobility assistance in bed requiring substantial assistance and being dependent upon staff to lie down and sit up. Analysis of findings identifies this problem as being a potential for problems. The only area checked for existing pressure injury is to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. No extrinsic factors were identified to include a problem with pressure, sheering, maceration etc. Intrinsic risk factors identified include altered mental status, cognitive loss, incontinence, and poor nutrition. Medications that increase risk for pressure injuries include antipsychotics, antidepressants, and opioids. Diagnoses that present complications or increase pressure injury risk included diabetes, chronic or end stage renal disease, peripheral vascular disease, other dementia, depression, severe pulmonary disease, and pain. Treatments and other factors that cause complications or increase risk was newly admitted or readmitted . Care plan considerations documented yes, pressure injury/functional status will be addressed in the care plan. The overall objective was improvement and avoid complications. The rationale for care plan decision documented: Resident is a [AGE] year old female with pmhx (primary history) (sic) of metabolic encephalopathy, seizures, senile dementia, COPD (chronic obstructive pulmonary disease), exacerbation of persistent asthma, AKI (acute kidney injury), anemia, hypothyroidism, HTN (hypertension), T2DM (type 2 diabetes mellitus), chronic pain, current smoker, bipolar 2, paranoid schizophrenia, anxiety, depression. CAA triggered d/t (due to) resident needing extensive assistance with ADLs and being at risk. Assistance provided every shift by licensed nursing assistants. Based on the following above (sic), will continue to care plan. R14's Plan of Care (POC) for Impaired skin integrity initiated: 9/2/25; with a created date of 12/18/25 by Wound Registered Nurse (WRN) -L identified the focus as: Left 1st MTH (metatarsal head) arterial ulcer; right 1st MTH arterial ulcer; coccyx unstageable pressure injury; right coccyx unstageable pressure injury;The Goal is to not experience complications from skin condition requiring hospitalization until wounds are resolved. Target Date: 2/28/26. Interventions identified for R14 included: Surveyor noted all identified interventions have a created date of 12/18/25 by WRN-L. (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 9/2/25 Address pain prior to treatment to improve resident tolerance acceptance of wound care.- 12/15/25 Assist resident to shift weight while up in chair at least once an hour.- 9/2/25 nursing to monitor dressing integrity with each resident encounter and replaced dressing if soiled/ loose/ missing. Dressing location (sic): right 1st MTH, coccyx. - 9/2/25 Referral to Registered Dietitian for evaluation related to impaired nutrition impacting wound healing period provide supplements per MD /NP (Medical Doctor/Nurse Practitioner) orders.- 9/2/25 Studies/labs to be performed as needed for diagnostics per MD/ NP orders.- 9/2/25 Wound measurement is performed weekly and PRN (as needed) by Wound Care Team. If resident is unavailable, assessment will be completed at earliest availability.9/2/25 Wound care treatment to be performed by Wound Care Team/ nursing as ordered by MD/NP. R14's care plan for ADL self-care performance deficit r/t (related to) metabolic encephalopathy. was initiated 11/27/24, revised 12/5/24. The Goal is to improve current level of functioning through the review date initiated 5/2/25, revised 12/3/25 with a target date of 12/2/25 (prior to the last revised date). Interventions included were: - 4/15/25 (R14) is weight bearing as tolerated. Revised 4/15/25 - 3/16/25 enabler/assistive device placed bilaterally to improve mobility and increase independence and safety. Revised 10/31/25 - 11/27/24 Bed Mobility: requires minimal assist with bed mobility. Revised 4/15/25 - 11/27/24 Toilet use: is dependent/Hoyer/2 assist for toilet use. Revised 5/5/25. -11/27/24 Transfer: requires Hoyer and two assist for transfers. Revised 5/5/25. R14's falls care plan initiated 11/27/24 and revised 10/13/25 included interventions that may have impacted R14's ability to reposition or be repositioned including body pillows on both sides of resident while in bed initiated 10/15/25; bolster mattress on bed initiated 10/17/25; and Dycem in wheelchair initiated 5/12/25. (R14) was to be up in wheelchair after lunch in the common areas initiated 5/19/25. R14's care plan for altered respiratory status. initiated 11/27/24, revised 12/5/24 included an intervention initiated 11/27/24 and revised 12/5/24 to elevate the head of the bed to 30 degrees. R14 also had a care plan for at risk for further impaired skin integrity related to: age, DM11 (diabetes mellitus), sepsis.This care plan identifies historical wound areas for R14. The goal was to not develop further skin impairments initiated 5/2/25 revised 12/18/25 with a target date of 2/28/26. Interventions included: - 11/27/24 assist to turn and/or reposition every 2-3 hours (not individualized). - 11/27/24 Barrier cream with incontinence episode and as needed. - 11/27/24 Braden upon admission, weekly times 4 weeks, quarterly, and as needed. - 11/27/24 Educate resident/family/caregivers of causative factors and measures to prevent skin (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	injury. - 11/27/24 Encourage good nutrition and hydration in order to promote healthier skin. - 11/27/24 Float heels if resident cannot turn and reposition themselves. Utilize pillows for offloading d/t abnormal positioning of feet. Revised 12/18/25. - 11/26/25 Follow facility protocols for treatment of injury. - 11/27/24 Keep skin clean and dry. Lotion skin with cares. Do not apply lotion between toes. Revised 12/6/24 - 11/27/24 – Monitor skin during cares. Report any changes to nurse. - 11/27/24 Obtain blood work such as CBC (complete blood count) with Diff (differential), blood cultures, and C&S (cultures & sensitivity) of any open wounds as ordered by physician. - 11/27/24 Weekly licensed nurse skin evaluation. R14's Nursing Progress Notes dated 12/15/25, written by RN-H, documented: Notified the POAHC regarding new order for wounds. Review of R14's medical record indicated a comprehensive assessment was not completed on 12/15/25 of the (potentially) 2 new, facility acquired unstageable wounds R14 developed. On 12/15/25 a treatment was added to R14's Treatment Administration Record (TARs) that stated: cleanse coccyx wounds with normal saline (NS), skin prep to peri wound, cover with Medihoney mesh (cut to size), followed by border foam dressing. Change 3 times a week and as needed. Every, day shift on Monday, Wednesday and Friday for unstageable times 2. R14's TAR does not indicate this treatment order was documented as being completed on 12/15/25 and 12/17/25. R14's December 2025 TAR documented: APM (alternating pressure mattress) initiated 12/15/25. On 12/15/25 Physiatry Assistant (PA)-J documented at 17:14 (5:14 pm) .Today patient is evaluated as I continue to follow the patent to optimize treatment and facilitate discharge. Patient continues with neuromuscular deconditioning with activities of daily living and/or gait dysfunction. Patient is a poor historian. Denies acute pain today. Reports generalized pain with long periods in w/c (wheelchair). See Pain assessment.Denies change in appetite or sleep. Pain assessment: unable to rate. Acute, generalized, intermittent pain. Worse with ling periods in w/c. Relieved by oxycodone, repositioning/laying down. Plan/recommendation: .Due to OA (open area) with pain and decreased mobility patient is high risk for falls. DM2 (diabetes mellitus type 2) Due to DM2 patient is high risk for poor healing and at high risk for infection that could necessitate the need for IV (intravenous) and readmission to the hospital.Surveyor noted there was no discussion or follow up to assess R14's care plan and time R14 spends up in a wheelchair despite indications it was contributing to pain and increased pressure to R14's bottom/lower back. The facility provided Surveyor with R14's wound assessments. The assessment forms included a picture of the wounds that are dated and time stamped to reflect the date they were created/completed by WRN-L. (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 12/18/25 assessment, time stamped at 9:44 AM, documented -R14 had a facility acquired, unstageable pressure injury to the coccyx assessed on 12/18/25 at 9:44 AM. The assessment documentation indicated the coccyx wound was identified on 12/15/25. The wound on 12/18/25 measured 1.2 centimeters (cm) x (by) 1.30 cm x 0.10 (length by width by depth). The wound bed is documented as 100% slough with scant serous drainage. The surrounding skin has erythema (redness) and maceration (breakdown of skin by moisture). Also, on 12/18/25 the assessment for R14 documented R14 had a second facility acquired, unstageable pressure injury with this area noted to be on R14's right coccyx. The first comprehensive assessment of this area was dated 12/18/25 at 9:48 AM. The wound assessment documentation identified this area as originally identified on 12/15/25. The right coccyx wound measured 0.90 cm x 1.30 cm x 0.10. The wound bed is documented as 90% slough and 10% red (not further clarified). Scant serous drainage is documented. The surrounding skin area is documented as having erythema and maceration. R14's care plan for at risk for further impaired skin integrity related to: age, DM11 (diabetes mellitus), sepsis.This care plan identifies historical wound areas for R14. The goal was to not develop further skin impairments initiated 5/2/25 revised 12/18/25 with a target date of 2/28/26. Interventions updated 12/18/25 included: - 11/27/24 Pressure reduction mattress. Alternating pressure air mattress. Revised 12/18/25. - 11/27/24 The resident needs pressure reducing cushion to protect the skin while up in wheelchair. Specialty cushion – Vicair. Revised 12/18/25. Surveyor noted these intervention were after R14 developed the two facility acquired coccyx pressure injuries on 12/15/25 and despite R14 being at risk for pressure injuries prior to the development of these areas. Review of R14's TAR indicated the treatment for R14's coccyx pressure injuries was not documented as completed on 12/19/25. On 12/19/25 a nursing progress note documented: An Interdisciplinary Meeting (staff were not identified) was held. Wounds: coccyx unstageable; initial assessment; alternating pressure mattress (APM); new treatment placed. Coccyx right unstageable; initial assessment; APM; new treatment placed. Dietitian: Boost twice a day (BID), PM (evening) snack, ice cream BID (twice daily). Continue with current care plan. Update Provider weekly. On 12/19/25 at 15:45 (3:45 PM) PA-J assessed R14 and documented .Complains of acute on chronic b/l (bilateral) knee pain today. Denies change in appetite or sleep. Nursing treating unstageable PI (pressure injury) of coccyx. Due to OA (open area) with pain and decreased mobility patient is high risk for falls. DM2 (diabetes mellitus type 2) Due to DM2 patient is high risk for poor healing and at high risk for infection that could necessitate the need for IV (intravenous) and readmission to the hospital. Unstageable PI of coccyx: wound MD following. Encourage repositioning q2hr (every two hours) and PRN to decrease pain and pressure areas. Continue orders per wound team. On alternating pressure air mattress, Boost BID for wound healing. Discharge planning: pending ALF (adult licensed family home) placement. A nursing progress note dated 12/21/25 at 18:02 (6:02 PM) documented: (R14) stayed in bed throughout the weekend due to increased pain from coccyx wound. She was repositioned from side to side q (every) 2 hours. Resident was given assistance in eating to encourage adequate intake. Surveyor noted that despite documentation of pain and changes in R14's activity and eating there was (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	no assessment of R14's wounds. The weekend included 12/19, 12/20, and 12/21/25. R14's coccyx Wound assessment dated [DATE] at 10:49 AM by WRN-L documented: measurements of 2.80 cm x 2.30 cm x 2.8 cm with the wound bed having 90% loosely adherent slough and 10% bright pink or red (not specified or further detailed) with moderate serous drainage. The peri-wound was documented as having erythema. There is undermining present between 12 o'clock and 1 o' clock 2 cm and between 5 o'clock and 6 o'clock 2 cm. The picture of the coccyx wound has a date and time stamp of 12/22/25 at 10:46 AM. Pain is documented as 3 on the pain scale. The assessment included documentation of probable improvement despite the increased size of the wound and undermining. Surveyor noted there is no assessment of the right coccyx wound dated 12/22/26. On 12/22/25 at 14:41 (2:41 PM), imagining was performed on R14's coccyx due to pain and wound decline. Reason for the study is documented as osteomyelitis, unspecified. Findings: Question subtle bone loss of the dorsal aspect of the sacrum/coccyx. Soft tissues appear swollen with ulceration dorsally. Conclusion: Cannot exclude osteomyelitis, recommend MRI work up. The radiology report included a handwritten note that documented MRI of sacrum coccyx for Dx (diagnosis) osteomyelitis signed as reviewed by NP-I on 12/23/25. Surveyor noted there are no additional orders documented to order and schedule an MRI, potentially obtain a culture and sensitivity of R14's wound, or treatment despite indications R14 had osteomyelitis. On 12/22/25 at 16:08 4:08 PM) a nutrition/dietary note was completed by Dietitian-G that documented: F/U (follow up) skin. Per wound assessment 12/22, unstageable PI – coccyx & laceration – vascular. Per wound assessment 12/18, unstageable PI-R (right) coccyx. PIs are new. Has hx (history) of PIs that had healed; however, these are new. Receives regular – mech (mechanical) soft diet which is approp (appropriate). Appetite is fair with po (oral) intake at 50%-100%. Receives Boost BID, ice cream lunch & dinner, and scheduled snack for nutritional support. Suspect current po intake + (plus) supp (supplements) approp to support skin. Cont (continue) POC (plan of care) and monitor at this time. Surveyor noted there is no indication Dietitian-G was made aware of or assessed the documentation by nursing staff that R14 had required greater assistance in eating to ensure intake related to increased pain due to R14's pressure injuries. R14's 12/22/25 at 16:30 (4:30 PM) assessment by PA-G documented. Chief complaint: Mobility and ADL impairment due to alzheimer's disease and charcot arthropathy, now with coccygeal pain. Complains of increased coccygeal pain today. See pain assessment. Denies change in appetite or sleep. Nursing treating unstageable PI of coccyx. Pain assessment: location: coccyx, acute intermittent, intensity of 5 out of 10. Worse with lying in bed. Relieved by repositioning.current pain medications include acetaminophen 650 mg (milligrams) TID (three times daily), and 650 mg q6hr (every 6 hours) PRN, Lidocaine patch 4% qd (each day), oxycodone 5 mg BID, biofreeze gel 4% BID.Plan/recommendations: Discussed plan of care with patient. XR (x-ray) sacrum/coccyx pending per primary care d/t increased pain and new wound; primary team to f/u on results. Patient to continue current medications and rehabilitation services per orders. Due to OA with pain and decreased mobility, patient is at high risk for falls. Dysphagia: on mech (mechanical) soft diet, thin liq (liquids). Due to dysphagia, patient is at high risk for aspiration pneumonia, that could require readmission to the hospital. Patient to maintain upright position with eating and for at least 30 minutes after meals. Encourage small bites (1/2 to 1 teaspoon at a time) alternating with small sips. DM2 (diabetes mellitus type 2) Due to DM2 patient is high risk for poor healing and at high risk for infection that could necessitate the need for IV (intravenous) and readmission to the hospital. Unstageable PI of coccyx: wound MD following. Encourage repositioning q2hr (every two hours) and (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PRN to decrease pain and pressure areas. Continue orders per wound team. On alternating pressure air mattress, Boost BID for wound healing. Discharge planning: pending ALF (adult licensed family home) placement. On 12/23/25 R14 was accompanied by R14's POAHC-CCC to obtain custom orthopedic shoes and braces in the community in preparation for discharge planning. Nursing progress notes dated 12/23/25 at 16:32 (4:32 PM) documented: Resident continues to show s/sx (signs/symptoms) of pain r/t coccyx wound, dressing changed d/t soiled with drainage from wound. Resident appears to be pocketing food, diet downgraded to puree (sic), nectar thick liquids. Surveyor noted that despite documented drainage from R14's pressure injury soiling the dressings R14's pressure is not reassessed and there is no consultation with R14's physician or nurse practitioner despite knowledge R14 has osteomyelitis in their coccyx pressure injury. Surveyor also noted there is no order for assessment or diet downgrade despite the documented change of condition of R14 pocketing food. (Cross-reference F684). Surveyor located a Diet Change Form dated 12/23/25 for puree and nectar liquids that was presented to the kitchen to implement the diet change despite no orders or assessment for the diet downgrade or change in R14's eating ability. On 4/15/26, at 10:15 AM, Surveyor interviewed Dietitian-G regarding R14. Surveyor asked Dietitian-G about the documented nutritional assessment on 12/22/25 where Dietitian-G documented no nutritional changes for R14 and R14's intake was good. Dietitian-G explained to Surveyor they were not aware that R14's coccyx pressure injury had become infected; they were aware there were unstageable wounds. Surveyor asked Dietitian-G about labs that had been run on R14 twice in December and the results indicating changes in R14's hydration status and kidney functions along with protein and albumin changes. Dietitian-G indicated they were not aware of the lab results for R14. Surveyor asked Dietitian-G about R14's changes in eating, consistency changes, and potential need for greater assistance from staff to ensure intake. Dietitian-G indicated they were not aware of any eating concerns or diet changes. Surveyor asked Dietitian-G if they had been aware of these issues regarding R14 what would they have potentially done. Dietitian-G stated if they were aware of the infection, lab results and diet changes, they would have made nutritional changes for R14. NP-I's progress note dated 12/23/25 documented: (R14) is seen today due to concerns about the worsening of her wound. An x-ray of her sacral coaxal area was performed, which could not rule out osteomyelitis. (R14) has experienced further decline and is now pocketing her food. She has complex medical history that includes metabolic encephalopathy, COPD, type 2 diabetes, immunodeficiency, peripheral vascular disease, bipolar disorder, dementia and schizophrenia. Vitals signs: Blood Pressure 149/86, Temperature: 98.2, Pulse 97 bpm (beats per minute), Weight: 165 lbs. Respirations 18 breaths per minute, pulse oximetry 96%. Physical Exam results: heart rate is regular with normal rhythm, lung sounds are clear throughout, patient is stable and in no acute distress. Assessment: 1. Worsening wound condition: unable to rule out osteomyelitis based on the x-ray, patient experiencing a decline indicated by pocketing food, complex medical history complicates the medical picture. 2. Comprehensive Medical Background: metabolic encephalopathy, COPD, type 2 diabetes; immunodeficiency and peripheral vascular disease, bipolar disorder, dementia, and schizophrenia. Plan: 1. Worsening wound condition: discuss and initiate hospice services under the guidance of (R14's POAHC-CCC), continue in-house wound care with nursing staff support to monitor (R14's) comfort. 2. Comprehensive Medical Background: Coordination and communication with (R14's POAHC-CCC) regarding goals of care; continued support from nursing staff. Signed NP-I. NP-I did not order any diet changes or downgrades to R14's diet or assessment despite noting a (continued on next page)

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	05/07/2026

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	potentially significant change that could impact healing of R14's pressure injury(ies). NP-I's progress note dated 12/24/26 documented: (R14) was seen today for a follow up regarding her long-term care goals. She has a coccyx wound with concerns for osteomyelitis, confirmed on x-ray. Over time, her overall condition has declined further, and she now displays significant difficulty swallowing, as evidenced by her pocketing food. Her diet was previously downgraded to mechanical soft foods with nectar thick liquids. The patient's (POAHC-CCC), who serves as her activated power of attorney, is in agreement with transitioning (R14) to hospice care services to prioritize her comfort moving forward. The objective vital signs documented vital signs similar to those documented on 12/23/25 by NP-I, there was a documented change regarding R14's lung sounds which documented diminished in bases. Physical exam: Patient is stable and in no acute distress. Diagnostic test results: X-ray findings support concerns for osteomyelitis in the coccyx. Assessment: 1. Coccyx wound with concerns for osteomyelitis, contributing to ongoing wound management challenges. 2. Difficulty swallowing: Patient exhibits pocketing of food, posing complications with oral intake and requiring modification of diet. 3. Declining overall condition: The patient continues to experience progressive clinical decline, necessitating a shift in care goals towards comfort and end-of-life services. Plan: 1. Coccyx wound with concerns for osteomyelitis: maintain in-house wound care management, ensure continued attention to wound healing and prevention of further complications. 2. Difficulty swallowing: continue the downgraded diet of mechanical soft foods and nectar thick liquids to reduce risk of aspiration, monitor for

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interview, and record review, the facility did not ensure 3 residents (R) of 4 residents reviewed were provided with adequate supervision and assistance to prevent accidents (R11, R5, and R13.) *R11 had an unwitnessed fall, without injury, on 2/13/2026. The facility did not implement immediate fall interventions, complete a fall investigation, determine a root cause, or review/revise the fall care plan to prevent further falls. R11 experienced another fall on 2/14/2026, which resulted in a laceration to R11's right eye and a Traumatic Brain Injury (TBI) requiring admission to a Neurology Intensive Care Unit. *R5 is documented as being dependent on staff for all cares. On 4/5/26, Certified Nursing Assistant (CNA)-X was performing cares alone with R5 in bed. R5 was facing away from CNA-X and when CNA-X turned away from R5 to grab supplies to perform cares, R5 rolled away from CNA-X and fell out of bed onto the floor. R5 was sent to the emergency room (ER) on 4/9/26 and diagnosed with bilateral tibia and fibula fractures (bone fractures in the lower legs typically caused by high-energy twisting injuries.) The facility failed to utilize standards of practice with bed mobility and cares for a resident who is dependent on staff for cares. The facility continued to transfer R5 via Hoyer lift and manipulate R5's Bilateral Lower Extremities (BLE) without assessing R5 when it was previously described by staff as having to manipulate R5's BLEs due to R5's contractures. The facility's failure to provide adequate supervision and proper assistance to R11 and R5 created a reasonable likelihood for serious harm, thus leading to the finding of immediate jeopardy that began on 2/14/2026. Surveyor notified the facility of the Immediate Jeopardy on 4/20/26, at 3:57 PM. The immediate jeopardy was removed on 4/23/26 when the facility implemented a removal action plan. The following example involving R13 is being cited at a scope/severity of D (potential for more than minimal harm/isolated): *R13 experienced an unwitnessed fall on 3/16/2026, without injury. The facility did not determine a root cause for R13's fall and interventions were not implemented. R13 experienced another unwitnessed fall on 3/24/2026, with no injuries and neurological checks were not completed due to not having a nurse, per the facility's documentation. Findings include: The facility's policy titled Accidents and Supervision, with a last reviewed/revised date of 10/8/2024, documents: 1. Identification of Hazards and Risks . a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying hazards of the environment, while taking into consideration the unique characteristics and abilities of each resident. B. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. A. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. b. Both the facility-centered and resident-directed approaches include evaluating hazards and accident risk (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. C. Evaluations also look at trends such as time of day, location, etc. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes: . f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. 1.) R11 was admitted to the facility on [DATE] with diagnoses that include history of Subarachnoid Hemorrhage and aneurysm, (Status post clipping on 12/2025,) chronic foley catheter, intrabdominal drain, hemiplegia (severe or total paralysis on one side of the body caused by brain or spinal cord damage,) hemiparesis (one-sided muscle weakness,) and muscle weakness. R11's admission Minimum Data Set (MDS), dated [DATE], documents that R11 was assessed to have severely impaired cognition, impairment on 1 side of upper and lower extremities, is dependent on staff for all Activities of Daily Living (ADLs,) dependent on staff to roll left to right, and has no history of falls and no care area for falls triggered. R11's admission Fall risk assessment dated [DATE], indicates R11 is a low fall risk. R11's readmission Fall risk assessment dated [DATE], indicates R11 is a moderate fall risk. R11's Fall risk Care plan, initiated 1/16/2026, documents the following interventions: -Be sure R11's call light is within reach and encourage R11 to use it for assistance as needed. R11 needs prompt response to all requests for assistance -Follow facility protocol. The facility provided document titled Visual/Bedside Kardex Report for R11 documents the following: R11 is an assist of 1 staff to turn and reposition, toileting. Ensure call light within reach and a mechanical lift for transfers with 2 staff assistance. Surveyor reviewed R11's Electronic Health Record (EHR) and noted a progress note, dated 2/13/2026, written by Registered Nurse (RN)-II indicating RN-II was alerted to a loud crash, and went to R11's room. R11 was observed lying on R11's right side, on the floor, alongside R11's bed. R11 was sent to the emergency room for evaluation and returned to the facility on 2/14/2026. Surveyor noted R11 did not sustain any injuries due to this fall. Surveyor noted there were no immediate interventions implemented, no fall investigation completed, no review of R11's care plan, and no revision/update to R11's fall interventions. R11's Fall Risk Assessment completed on 2/13/2026, indicates R11 is a high risk for falls. Despite the fall risk assessment dated [DATE], Surveyor noted no update to R11's fall care plan occurred. (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R11 had another unwitnessed fall on 2/14/2026. Surveyor reviewed R11's EHR and noted a progress note, dated 2/15/2026 at 1:15 AM, written by Licensed Practical Nurse (LPN)-F indicating LPN-F was notified at 11:15 PM on 2/14/2026, that R11 was on the floor in R11's room. LPN-F observed R11 face down on the floor on R11's right side with a laceration to R11's left eye lid, noting a moderate amount of blood. 911 was called and R11 was transported to the emergency room for evaluation. Surveyor was unable to locate an investigation for this fall. R11's care plan was updated and indicates R11 sustained a fall on 2/15/26 with head injury, created on 2/23/2026. R11's Post-Fall Risk Assessment, dated 2/14/2026, indicates R11 is a moderate fall risk. Surveyor noted R11 did not return to the facility and was transferred to another facility after discharging from the hospital. Surveyor reviewed the emergency room after visit summary, dated 2/15/2026, which documents: - CT (computed tomography) of R11's head shows an area of concern for acute hemorrhage compared to previous CT Problems Addressed: Intraparenchymal hemorrhage of brain (a severe traumatic brain injury (TBI) where blood vessels rupture inside the brain tissue) (CMS-HCC): complicated acute illness or Injury and indicates, given new traumatic intracranial hemorrhage, R11 will require admission to neuro Intensive Care Unit (ICU.) On 4/15/2026, at 9:00 AM, Surveyor was informed by Clinical Nurse Specialist (CNS)-B that there was not a process in place for fall investigations prior to CNS-B coming to the facility and CNS-B began implementing a process about 1 week ago which included fall packets and expectations of fall investigations. CNS-B indicated R11's falls on 2/13/2026 and 2/14/2026 were not investigated for root cause. On 4/15/2026, at 1:08 PM, Surveyor interviewed LPN-F. LPN-F indicated on 2/14/25 LPN-F was informed by a CNA that R11 was on the floor in R11's room. LPN-F indicated they did not have a CNA assigned to R11's assignment that evening until 11PM. LPN-F observed R11 on the floor with an injury to R11's right eye. LPN-F called RN/PM Supervisor-D and R11 was ultimately sent to the emergency room for evaluation. LPN-F informed Surveyor that LPN-F did not complete a fall investigation and has not been trained on that. On 4/16/2026, at 9:02 AM, Surveyor interviewed RN/PM Supervisor-D. RN/PM Supervisor-D informed Surveyor an RN will perform the assessment of the resident after a fall and put what happened into a progress note, complete the fall packet, and implement immediate interventions. The unit manager the next day will review the fall packet and ensure immediate interventions are implemented and care plan reviewed/revised. The Intradisciplinary Team (IDT) will review the fall investigation the next day during morning meetings, but indicated RN/PM Supervisor-D is not part of the morning IDT meetings. (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/20/2026, at 10:15 AM, Surveyor interviewed Unit Manager (UM)-E. UM-E indicated R11 did not have fall investigations completed and that now fall packets are completed by the floor nurse assigned to the resident who also implements an immediate intervention; the unit managers will review the fall packets and bring to morning meetings for IDT review to ensure care plan review and revisions. 2.) R5 was admitted to the facility on [DATE] with diagnoses that include congenital hydrocephalus (water on the brain causing symptoms of cognitive difficulties like memory loss), contracture of bilateral upper extremities (fibrous tissue injury resulting in lack of movement in the arms), contracture of bilateral lower extremities (fibrous tissue injury resulting in lack of movement in the legs), osteoarthritis (OA) (tissue in the joints, break down causing pain, stiffness, swelling and reduced mobility), and history of falls and seizures. R5's Significant Change Minimum Data Set (MDS) completed on 4/2/26, documents that R5 was assessed to be dependent with all cares (including toileting, transfers, eating, and dressing.) R5 is frequently incontinent of bowel and bladder. R5 was documented as having a Brief Interview for Mental Status (BIMS) score of 9, indicating that R5 has moderate cognitive impairment. R5's Care Area Assessments (CAA) document: Cognitive Loss/Dementia CAA: R5 has cognitive decline and needs limited to extensive assistance with Activities of Daily Living, mobility and bowel and bladder management. Falls CAA: R5 receives psychotropic medications and needs extensive assistance with ADLs, mobility and bowel and bladder management. R5 is at risk for falls, with and without injury. The plan is for nursing staff to monitor R5's safety. The goal is for R5 to remain free of falls while residing at the facility. R5's care plan dated 6/22/22, documents: R5 is at risk for falls, accidents and incidents related to unawareness and safety needs. R5 will fall from the bed or chair as a behavior. R5 has been noted to throw themselves on the floor. R5 will be half in bed and half out of bed at times (date initiated 1/23/26, revised on 1/23/26). Interventions include, in part: Be sure R5's call light is within reach and encourage R5 to use it for assistance as needed (PRN). R5 needs prompt response to all requests for assistance (date initiated 2/19/25, revised on 1/23/26). Bed to be kept in lowest position (date initiated 10/11/25). Body pillows to be placed on both sides of R5 while in bed (date initiated 10/11/25). Hourly rounding or placement in common areas for monitoring (date initiated 10/22/25). Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter or remove any potential causes if possible. Educate R5/family/caregivers/Interdisciplinary Team (IDT) as to causes (date initiated 10/22/25). Use bilateral body pillows (date initiated 6/9/25). (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Use bilateral floor mats (date initiated 5/2/25). Use bolsters on bed (date initiated 10/1/25). Educate R5 to call for assistance (date initiated 8/3/22, revised on 6/2/24). Ensure bed brakes are locked (date initiated 6/22/22). Ensure two staff members are present during cares and interactions with R5 (date initiated 1/18/25, revised 4/9/26). If increased restlessness or anxiety, encourage R5 to be up in the wheelchair in the common area (date initiated 6/8/25). R5 has an ADL self-care performance deficit and limited physical mobility related to right intertrochanteric femur fracture status/post Open Reduction and Internal Fixation (ORIF), fall, acute blood loss anemia, GERD, constipation, insomnia, congenital hydrocephalus with a shunt, seizures and Osteoarthritis (OA) (date initiated 6/22/22, revised on 5/2/25). Interventions include: Personal Hygiene: Physical assist of 1 staff member (created on 6/22/22, revised on 10/5/22). Ensure there is a pillow placed in the broda chair to the right side to assist with arm positioning (date initiated 12/31/24). Bathing: Physical assistance of 1 staff member with reclining shower chair to be utilized when providing a shower (date initiated 6/22/22, revised on 9/3/23). Dressing: Physical assistance of 1 staff member (date initiated 6/22/22, revised on 10/5/22). Toileting: Assistance of 1 staff member with a bedpan and incontinence care (date initiated 6/22/22, revised on 7/14/24). Transfer: R5 requires a Hoyer lift with 2 staff assistance (date initiated 7/8/22, revised on 6/21/24). Surveyor reviewed R5's Kardex which documents the following: Dressing – assistance of 1 staff member Bed Mobility – is not filled out and does not specify the number of staff members needed for R5's bed mobility Transfers – Hoyer lift requiring 2 staff members for assistance Hourly rounding or placement in common areas for monitoring Ensure two staff members are present during cares and interactions with resident (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Bathing – assistance of one staff member with bathing Surveyor reviewed R5's Fall Risk Assessments which document: 2/21/26 – R5 is high risk for falls 3/3/26 – R5 is high risk for falls 3/22/26 – R5 is high risk for falls 4/5/26 – R5 is a moderate risk for falls Surveyor notes R5 had a fall with injury on 4/5/26 and was documented as being a moderate risk for falls with all other fall risk assessments indicating R5 is high risk for falls. Surveyor reviewed R5's Electronic Medical Record (EMR) which documents R5 having an Unwitnessed Fall (UWF) on 3/22/26, at 11:07 PM. Surveyor reviewed R5's fall investigation dated 3/22/26, which documents the following: On 3/22/26, at 11:07 PM, R5 was found lying on the floor next to the bed. R5 was last seen and toileted at 10:00 PM. Skin Assessment completed which documents R5 having an abrasion/bruise (no location of where abrasion and bruise are located/documented. There is a check mark indicating abrasion and bruising.) Laceration to the left side of R5's nose measuring 0.1 x 0.1 cm. A laceration to R5's right side of the head measuring 0.2 x 0.1 cm. Pain assessment completed documenting R5 denied pain. Neurological checks were completed with one missing entry noted on 3/23/26 at 5:15 PM (4-hour neurological check). Registered Nurse (RN) assessment completed with vital signs documented as within normal limits. The facility notified Hospice, APOA, Medical Director (MD) and R5's community case manager of R5's fall on 3/22/26. Surveyor notes the following concerns with R5's 3/22/26 fall investigation: A thorough root cause was not identified. No indication the care plan was thoroughly reviewed to identify if interventions are appropriate or additional interventions are needed. The Interdisciplinary Team (IDT) met and identified R5 as being a very high fall risk with unavoidable behavioral fall pattern. The unavoidable behaviors are not identified, and the IDT does not indicate the unavoidable conditions that contribute to R5's falls. (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/26, at 7:25 AM, Surveyor interviewed RN/PM Supervisor-D who stated the therapy department determines the number of staff needed for assistance with performing cares. Surveyor asked RN/PM Supervisor-D why R5 has falls and RN/PM Supervisor-D responded that she is not sure why and then stated R5 is supposed to be an assist of two staff members and a buddy system. RN/PM Supervisor-D stated if a resident does not have good body coordination, that resident could roll right off the bed. On 4/15/26, at 12:40 PM, Surveyor interviewed LPN-EE who stated the therapy department usually reviews and updates resident's care plans and Kardexes to determine the number of staff required for assistance with a resident. LPN-EE stated she will contact an RN in the building for an assessment with any change in condition, obtain vitals and notify POA, MD and case manager. LPN-EE stated R5 can be squirrelly in bed and try to move around and get out of bed at times. Staff will try to calm R5 down when R5 is squirrelly. LPN-EE stated R5 is a total assist, requiring assistance of two staff members with a Hoyer lift. LPN-EE then stated R5 requires assistance of one staff member with bed mobility and cares in bed. (Note: This is contrary to the care plan.) Surveyor reviewed R5's Electronic Medical Record (EMR) and facility self-report which documents R5 having a fall on 4/5/26 at 6:00 AM. Surveyor reviewed R5's fall investigation dated 4/5/26, which documents the following: Certified Nursing Assistant (CNA)-X was performing cares alone on R5 with R5 lying in bed. CNA-X had R5 facing away from her at the time of cares and R5 rolled out of bed. CNA-X did not see R5 roll out of bed but heard R5 roll out of bed. All interventions were documented as being in place. Immediate interventions were documented as putting the bed in the lowest position and bilateral body pillows to be placed. The root cause was documented as R5 had a high fall risk requiring 2-person assistance, however, care was performed with 1 staff member. Staff interviews were performed who worked night shift from 4/5/26 – 4/8/26. A statement from Medical Director (MD)-NN documents R5 exhibits impulsive behavior specifically history of forceful self-extraction from beds and chairs. These sudden movements combined with impaired judgement present an increased risk of falls. It is helpful to note that contractures create leverage on the bones. If R5 falls while a limb is contracted, the bone is much more likely to snap than a flexible limb would be. Chronic contractures severely limit R5's Range of Motion (ROM) and postural stability, making independent movement unsafe and increasing the physical stress on long bones during any sudden shift in position. Given R5's overall frailty and the mechanical stress caused by the aforementioned contractures and documented impulsive movements, R5 is a markedly increased risk for pathological, or trauma induced fractures. On 4/15/26, at 10:22 AM, Surveyor interviewed CNA-X who stated R5 is contracted in the fetal position with R5's knees approximately 10 - 15 inches away from R5's chin. CNA-X stated R5 was excited to see CNA-X on 4/5/26, and R5 was attempting to wiggle her way out of bed. CNA-X stated she would go into R5's room and ask if R5 was ok. CNA-X stated R5 could not say if anything was (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wrong. CNA-X stated she increased her rounding with R5 due to R5 consistently wiggling and attempting to roll out of bed. CNA-X stated she was working with R5 on 4/5/26 at 6:00 AM, performing cares on R5 while R5 was lying in bed. CNA-X turned away from R5 while performing cares and R5 then rolled out of bed. CNA-X did not see R5's actual fall from the bed. CNA-X only heard R5 fall. CNA-X stated she thinks R5 hit R5's head on the bedside table and rolled on to R5's body, on top of R5's legs. CNA-X immediately got two nurses who were at the nursing station. CNA-X stated R5 developed a bump on R5's head with no other noticeable injuries or bruising. Surveyor asked CNA-X to describe how staff utilize the Hoyer lift with R5's severe contractures. CNA-X responded, R5 is supported with R5's back and buttocks, depending on how R5 is adjusted in the Hoyer lift. Staff have to adjust R5's legs when putting R5 into the wheelchair so R5 doesn't sit on R5's legs or get them caught in the wheelchair. CNA-X stated the way R5's body is, R5 could easily sit on R5's legs with the Hoyer lift. When R5 is in bed, CNA-X stated, staff also have to be careful with the wedges for support. On 4/15/26, at 3:00 PM, Surveyor interviewed RN-DD who stated staff refer to the EMR and Kardex to determine the number of staff needed for assistance. RN-DD stated she was the charge nurse on 4/5/26 and was contacted by nursing staff to evaluate R5 post fall. RN-DD stated R5 was lying on the floor on the nightstand with R5's brief half on. R5 was on the floor lying on R5's right side of bed. RN-DD stated CNA-X indicated she was providing cares for R5 alone and reached to the nightstand when R5 rolled out of bed. RN-DD stated she performed neuro checks, pain assessment, skin check, contacted hospice and obtained vitals. RN-DD stated she rubbed R5's legs to see if R5 would wince and grimace. RN-DD stated R5 denied pain and noted no bruising to bilateral lower extremities. RN-DD stated facility staff assisted R5 back into bed using a Hoyer lift. On 4/14/26, at 12:55 PM, Surveyor interviewed Forensic Nurse-CC. R5 arrived at the ER for evaluation on 4/9/26, for left ankle deformity. ER staff noted R5 having extensive bruising on BLEs. Forensic Nurse-CC stated the ER was notified of R5 having a fall from bed on 4/5/26 that did not seem to correlate with the fall. Forensic Nurse-CC stated the hospice nurse arrived at the ER at the same time Forensic Nurse-CC arrived in the ER to evaluate R5. Forensic Nurse-CC asked R5 if anyone harmed R5, and R5 stated no, but then stated yes indicating someone had pushed R5. R5 was unable to state whether it was a resident or staff member who pushed R5. R5 denied pain at the time of evaluation when asked however, R5 would start moaning when ER staff picked up R5's BLEs. Forensic Nurse-CC stated she performed a skin assessment on R5 which documented the following: Round fingerprint bruise under chin, not on bony prominence. Significant intermittent bruising on left forearm and left wrist potentially from being grabbed. 3 to 4 finger like bruising impressions on right clavicle that were more vertical than horizontal. Left leg with significant bruising from just below the left knee. Mid-calf to the foot appeared swollen, ecchymotic and deformed. Right lower leg appearing swollen, ecchymotic and bruised. Forensic Nurse-CC stated, when staff picked up R5's left leg, it was floppy, and the left leg bent in half when being picked up. Forensic Nurse-CC stated x-rays were performed and revealed bilateral proximal and distal tibia and fibula fractures on both legs. Forensic Nurse-CC acknowledged R5 having a history of fractures in the past and then stated the radiologist determined the tibia and fibula fractures were acute fractures. (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/26, at 10:56 AM, Surveyor interviewed Nurse Practitioner (NP)-I who stated R5 is completely dependent on staff and requires two staff members for assistance. Surveyor asked NP-I who reviews and updates R5's care plan to determine how many staff are needed for assistance, and NP-I stated she would assume the therapy department determines the number of staff needed for assistance and cares. NP-I stated she was notified on 4/9/26 of R5's fall that occurred on 4/5/26. NP-I stated she was contacted by nursing staff on 4/9/26 regarding R5's change in condition post fall and having deformity and bruising. NP-I stated R5 had bruising on R5's shins that were purple with yellowing which indicated bruising didn't happen the morning of 4/9/26. NP-I advised staff to send R5 to the ER for evaluation. NP-I stated R5 has experienced multiple falls and is unsure when deformity to R5's left ankle occurred. NP-I stated behaviors often imply they are intentional, so NP-I stated R5 does not have behaviors because they are not intentional. NP-I stated she would describe R5 as being restless which can contribute to R5 falling out of bed. NP-I then stated terminal restlessness can be a cause of falls. On 4/15/26, at 8:58 AM, Surveyor interviewed Clinical Nurse Specialist-B who stated the expectation of every fall is to complete all checks listed below: *Fall Risk Assessment that includes when the resident was last seen, toileted, if interventions were in place and if immediate interventions were initiated. *Neuro checks *Vital signs *Skin assessment *Pain assessment *Notify Hospice, POA, MD and Case Manager *Root Cause *72-hour post fall assessment *Care plan interventions reviewed/evaluated/updated *IDT to meet to discuss fall On 4/16/26, at 3:23 PM, Surveyor interviewed NHA-A, Clinical Nurse Specialist-B, and Director of Operations-O. Director of Operations-O stated there was a delay in the facility's response with R5's change in condition and then notification of change was not properly completed. Clinical Nurse Specialist-B stated R5 is not truly an assist of one and CNA-X should have had another staff member with her. On 4/16/26, at 3: 23 PM Surveyor notified NHA-A, Clinical Nurse Specialist-B, and Director of Operations-O of the following concerns: *CNA-X was performing cares independently on 4/5/26, on R5 who is dependent on staff with all needs. (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*CNA-X failed to utilize standards of practice with bed mobility and cares for R5 who is dependent on staff for cares. *CNA-X rolled R5 away from her when performing cares. *The facility continued to transfer R5 via Hoyer lift and manipulate R5's BLEs without assessing R5 when it was previously described by staff as having to manipulate R5's BLEs due to R5's contractures. *R5 was evaluated in the emergency room (ER) on 4/9/26 and diagnosed with bilateral tibia and fibula fractures (bone fractures in the lower legs typically caused by high-energy twisting injuries.) *Statement from MD-16 documents R5 having known impulsive behaviors with a history of forceful self-extraction from bed and chairs. This is a known history with R5 having multiple recent falls with no indication R5's care plan was reviewed. *No recent ADL care plan revisions noted with last revisions documented in 2023 and 2024. *Conflicting documentation indicating R5 requires assistance of 1 vs 2 staff members on R5's care plan and Kardex. R5's care plan and Kardex document staff are to use the buddy system with cares, however, bathing, dressing, and toileting document 1 staff member needed. *Documentation and statements from Forensic Nurse-CC identify R5 with having bruises on the chin, clavicle, forearm, forehead, and BLEs. BLEs appeared swollen and ecchymotic with extensive bruising. R5's left leg bent in half when picked up. Acute spiral fractures were identified in both legs. *Incomplete fall investigation for R5's fall on 4/5/26. Surveyor identified no post fall evaluation, vitals, and no review of care plan interventions. *Fall Risk Assessment documented on 4/5/26 indicates R5 is a moderate risk. All other fall risks determined R5 to be high risk for falls. Clinical Nurse Specialist-B stated R5 is truly an assist of 1 staff member, but the facility has the buddy system of 2 staff members. Clinical Nurse Specialist-B stated CNA-X should have had another staff member with her when performing cares on R5 on 4/5/26. Surveyor noted that if this was the case, the R5's care plan should have reflected R5's transfer status as an assist of 2 staff members, not 1. The facility's failure to keep R11 and R5 free from hazards, reduce the risk of all known and foreseeable accident hazards that cannot be eliminated, provide appropriate and sufficient supervision to R11 and R5 to prevent an avoidable fall increased a reasonable likelihood for serious harm, thus creating a finding of Immediate Jeopardy. This Immediate Jeopardy was removed on 4/23/26 when the facility completed the following: A review of current residents who had falls in the last 30 days was completed to ensure the following: Physician notification; Risk management was completed; Care plan interventions are appropriate; Plan of care was followed In-house residents who are at high risk for falls had their plan of care reviewed and/or revised to (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ensure appropriate interventions in place. A list of sample post fall interventions was placed at the nurse's stations to assist the nurses in implementing new immediate fall interventions. A new fall review checklist was implemented which includes the following: Complete fall packet; Neuro checks; Fall evaluation; Skin evaluation; MD notification; Responsible party notification; IDT progress note including the RCA completed; Review of care plan and revisions as indicated An Ad hoc QAPI was completed to include the medical director Re-education to licensed nurses related to the facilities accident and supervision policy Re-education to the nursing staff related to the Stop and Watch tool which is placed at the nurse's stations. This training will include agency staff. Re-education to certified nursing staff related to Kardex review including buddy system and location of Kardex. Education to nursing staff related to bed mobility best practice of when to utilize assist of 2 for cares, repositioning, and toileting Re-education to licensed nurses related to the facilities notification of change policy initiated This training will include agency staff and new orientation. The Director of Nursing and/or designee will conduct an audit daily x 4 weeks during clinical start up to identify any notifications of change and proper notifications and follow-through made. The Director of Nursing and/or designee will conduct an audit daily x 4 weeks during clinical start up to ensure fall protocol is followed, fall checklist completed. While the immediate jeopardy was removed on 4/23/26 when the facility implemented the above action plan, however deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) for the following example: 3.) R13 was admitted to the facility on [DATE], with diagnoses including Dementia (a progressive, irreversible syndrome causing decline in memory, thinking, and behavior) and muscle weakness. R13's Quarterly MDS, with a reference date of 2/17/2026, documents a Brief Interview for Mental Status score of 12 indicating moderate cognitive impairment, R13 does not exhibit behaviors, requires partial/moderate assistance rolling left to right, sit to standing and transfers, experienced a fall since admission, and uses a manual wheelchair. R13's Fall Risk Assessments document: 2/3/2026- high risk 3/16/2026- moderate risk (continued on next page)

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	05/07/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3/24/2026- moderate risk 4/8/2026- high risk The facility provided document titled Care Plan Report for R13, indicates R13 is at risk for falls created on 1/20/2025 with the following interventions: -Ensure R13 is wearing leather shoes or non-skid socks when ambulating or mobilizing. Initiated 1/20/2025 -Follow facility protocol. Initiated 8/27/2025 -gripper socks on at all times. Initiate

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	05/07/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure 1(R12) of 2 sample residents with a foley catheter had indications for use, along with care and services.*R12 was observed with a foley catheter and did not have a physician order to indicate use, along with care and services.Findings include:R12 was readmitted to the facility on [DATE] with diagnoses that include urinary tract infection, neuromuscular dysfunction of the bladder and retention of urine.On 4/14/26, at 9:45 AM, Surveyor observed R12 in their room. R12 had a foley catheter bag with urine in it. R12 was asleep at this time in their bed.On 4/14/26, at 12:54 PM, Surveyor interviewed R12 in their room. R12 stated they do not know how long they have had the foley catheter but R12 thought it was over a year. R12 stated they have never seen a urologist and have asked facility staff about seeing one.Surveyor reviewed R12's medical record and noted that R12's current physician orders and plan of care summary does not document that R12 has a foley catheter. Surveyor was unable to locate any physician orders or a plan of care for R12's foley catheter or foley catheter care and services. On 4/15/26, at 8:30 AM, Surveyor interviewed Clinical Nurse Specialist (CNS)- B who is covering the unit R12 resides on. CNS-B reviewed R12's medical record during interview interview with Surveyor and stated that R12 had previous orders for the foley catheter prior to R12's readmission to the facility on 4/7/26. CNS-B informed Surveyor that there were no foley catheter indications for use, along with care and services, or physician's orders for R12's foley catheter put in place when R12 was readmitted on [DATE]. CNS-B stated there should have been physician orders put in place for R12's foley catheter and CNS-B stated she would obtain these orders.On 4/16/26, at 3:15 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, CNS-B and Director of Operations-O, Surveyor informed the facility of the above findings. No additional documentation was provided.

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	05/07/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents maintained acceptable parameters of nutritional status for 1 (R1) of 1 residents reviewed for weight loss.* R1 was admitted to the facility on [DATE] and the facility did not obtain an admission weight. On 4/8/2026, the facility weighed R1 and documented a weight loss of 19.9 pounds (lbs.) from R1's hospital discharge weight. R1's weight loss was not prescribed, no new interventions were implemented to prevent further weight loss, and facility did not obtain an additional weight for R1, per Registered Dietician (RD)-G's recommendation. Findings include:The facility policy titled Weight Monitoring last reviewed/ revised 10/30/2024 documents: Guideline: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preference indicate otherwise.1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: .b. Evaluating/analyzing assessment information.d. Monitoring the effectiveness of interventions and revising them as necessary.2. A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or in compromised nutritional status. Assessments should include the following information: .c. weight .3. The care plan should address the following .: .c. Identify resident-specific interventions . e. Updated as needed, such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or new causes of nutrition related problems are identified. f. If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate.5. A weight monitoring schedule will be developed upon admission for all residents: a. Weights should be recorded at the time obtained .b. Newly admitted residents- monitor weight weekly for four weeks.7. Documentation: a. The physician should be informed of a significant change in weight .R1 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, muscle weakness, cognitive communication deficit, dementia, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease (COPD).R1's admission Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 13, indicating that R1 is cognitively intact. The MDS documents that the the facility assessed R1 as needing assistance with meal setup, assistance of 1 staff member with activities of daily living (ADL's) and that R1 had an physician order for regular diet with regular fluids. R1's nutritional risk care plan initiated on 3/27/2026 documents the following interventions:- Administer medications as ordered. Monitor/ Document for side effects and effectiveness.- Obtain and monitor lab/ diagnostic work as ordered. Report results to medical doctor (MD) and follow up as indicated.- Provide and serve diet as ordered. Monitor intake.- Provide and serve supplements as ordered.- RD to evaluate and make diet change recommendations as needed.- Weigh as ordered or per facility protocol. Monitor for changes.R1 had the following physician order: Obtain weight upon admission then weekly for four (4) weeks. (Start: 3/26/2026)Surveyor reviewed R1's documented weights and noted R1's only weight documented was 183.8 lbs. (pounds) on 4/8/2026.Surveyor was unable to locate an admission weight obtained for R1 on 3/25/2026, when R1 was admitted to the facility, per R1's physician order. Surveyor reviewed R1's medication/treatment administration record (MAR/TAR) for March and April 2026 and noted staff documented weight not obtained for R1 on 3/26/2026 and 4/1/2026. Surveyor reviewed R1's nursing progress notes and could not locate any documentation that R1 refused to have a weight obtained.On 4/15/2026, at 10:06 AM, Surveyor interviewed RD-G who stated an admission weight was not documented for R1 so RD-G reviewed R1's hospital discharge paperwork and noted R1's weight in the hospital was 203.7 lbs. on discharge per hospital documentation. RD-G stated RD-G completed a nutritional assessment on R1 and initiated R1's care plan. RD-G requested a weight be (continued on next page)

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	05/07/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained for R1. On 4/8/2026 when RD-G followed-up with R1, RD-G noted R1's documented weight on 4/8/2026 was 183.8 lbs. indicating a 20 lb. weight loss from 3/25/2026 to 4/8/2026 (14 days).RD-G stated RD-G requested a re-weight for R1 and R1's weight loss was discussed in the morning interdisciplinary review team (IDT) meeting but is unsure what happened after that regarding R1's weight loss. RD-G stated RD-G was never ablet o follow up because R1 had discharged on 4/13/2026. Surveyor asked RD-G when should staff obtain a requested re-weight for a resident. RD-G stated a re-weight should hopefully be obtained within 24-48 hours preferably, if not the same day requested. Surveyor asked RD-G if R1 refused to get weighted. RD-G stated RD-G is unaware if R1 refused to get weighted. Surveyor asked RD-G when staff would review or revise interventions for R1's weight loss. RD-G stated the IDT meetings would review the care plan and revise if needed or RD-G would act on recommendations, however RD-G wanted a re-weight on R1 to confirm the weight obtained on 4/8/2026 was accurate.On 4/15/2026, at 12:27 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-HH who stated when a resident admits to the facility, staff are to obtain a weight on the resident if able. LPN-HH was not able to recall if LPN-HH obtained a weight on R1 when R1 was admitted to the facility in 3/25/2026. LPN-HH did not recall R1 refusing anything during R1's admission in the facility. LPN-HH stated if a resident refuses treatment, nursing staff is to document in the progress notes what was refused, why, and what interventions were implemented. LPN-HH stated nursing staff would follow up with the certified nursing assistant (CNA) staff to verify if a weight was obtained and why if not obtained.Surveyor asked LPN-HH if a re-weight is requested, how are staff notified and when should the re-weight be obtained. LPN-HH stated a re-weight should be obtained and reported when able to get it and staff are usually notified of a needed weight by looking at the 24 hour board or being told and passed down in end of shift report if it was not completed on the current shift.Surveyor reviewed the 24 hour boards for R1's unit and did not see a request for a re-weight needing to be obtained for R1.On 4/15/2026, at 2:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B, and Director of Operations (DOO)-O. NHA-A stated R1 discharged from the facility before a re-weight could be obtained. Surveyor asked what the expectation was for staff to obtain a weight once it was requested. NHA-A stated NHA-A would have to review the policy. Surveyor asked NHA-A to review all weights obtained at the facility for R1 and NHA-A stated they would have to get the information to Surveyor. On 4/15/2026, at 2:39 PM, NHA-A provided documented weights for R1. R1's weights were documented on 3/26/2026 as 203.7 lbs. and 4/8/2026 as 183.8 lbs. Surveyor asked where R1's weight was obtained from for the weight documented on 3/26/2026. NHA-A stated it looks like R1's weight documented on 3/26/2026 was pulled from R1's hospital discharge paperwork on 3/25/2026. Surveyor asked if staff could document a hospital weight or if a resident's weight should be obtained at the facility. NHA-A state NHA-A would have to check the policy but believes a resident's weight should be obtained at the facility upon admission when able and not taken from the admission paperwork.Surveyor shared concern with NHA-A that R1 did not have a weight obtained at the facility until 4/8/2026 (14 days after admission) and according to the hospital documented weight on 3/25/2026, it appeared R1 had lost 20 lbs. in 14 days. Surveyor shared concerns that R1's weights were not obtained per the facility's policy, and an additional weight was not obtained per RD-G's recommendation and R1's care plan was not reviewed or revised with interventions to avoid future weight loss or investigated thoroughly if R1 had an accurate weight obtained. NHA-A stated R1's weight should have been obtained on admission and re-evaluated after a discrepancy of 20 lbs. was documented.No additional information was provided.

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	05/07/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.*The facility did not ensure sufficient Certified Nursing Assistant (CNA) and nurse staffing was provided based on the facility's staffing plan and staffing patterns.This deficient practice has the potential to affect 98 of 98 residents in the facility.Findings include:On 04/01/2026, Surveyor reviewed the facility's assessment with an approved date of 08/29/2025. The facility assessment documents under Information About Our Staffing Patterns section: The staffing plan is based on the facility assessment, along with facility-based and community based risk assessments to inform staffing decisions to ensure that there are sufficient number of staff to care for the residents' needs. This document is updated and adjusted as necessary based on changes to the resident populations.On 04/01/2026, at 1:36 PM, Surveyor interviewed Scheduler-QQ regarding the facility's staffing patterns. Per Scheduler-QQ, the facility staffs Certified Nursing Assistants (CNAs) based on census and resident acuity. Scheduler-QQ informed Surveyor that the facility transitioned CNAs from twelve hour shifts to eight hour shifts around the beginning of March 2026. Per Scheduler-QQ, when the facility was utilizing twelve hour shifts for CNAs, there were 10 CNAs needed for the AM shift and 7 CNAs needed for the PM shift. When the facility transitioned to eight hour shifts for CNA staffing, the facility utilized 10 CNAs for first shift, 10 CNAs for second shift, and 7 CNAs for third shift.Surveyor reviewed the facility staffing patterns from 02/01/2026 through 04/14/2026. Surveyor noted the facility was short staffed on the following dates:02/14/2026 - 1 CNA short on PM shift.02/16/2026 - 1 CNA short on PM shift.03/02/2026 - 1 CNA short on PM shift.03/06/2026 - 1 nurse short on PM shift due to a no call/no show and 1 CNA short.03/13/2026 - 1 CNA short on PM shift and 1 CNA short on night shift.03/20/2026 - 2 CNAs short on night shift.On 04/02/2026, at 9:43 AM, Surveyor interviewed Scheduler-QQ and reviewed the above dates. Scheduler-QQ confirmed the facility was short staffed on the above dates. Surveyor asked Scheduler-QQ whom passed medications on the unit on 03/06/2026 when the nurse did not show up for the PM shift. Scheduler-QQ stated she did not know. On 04/16/2026, at 3:15 PM, during the facility exit meeting with Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B, and Director of Operations (DOO)-O, Surveyor informed the facility of the staffing concerns identified during survey.No additional information was provided.

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	05/07/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not provide medically related social services to a resident to maintain their highest physical, mental, and psychosocial well-being. This was observed with 1 (R14) of 16 residents reviewed for social services.*R14 had an activated Power of Attorney for Healthcare (POAHC) (CCC). In December 2025, R14 developed pressure injuries, a wound infection, a change in nutritional needs, and an order for Hospice services. There is no documentation of Social Service involvement with R14's clinical changes leading to suggestion of hospice services and coordination of the referral to hospice. Findings include:The facility's policy and procedure titled Social Services, undated, states the following guidelines: The facility, regardless of size, will provide medically related social services to each resident to assist in attaining or maintaining the resident's highest practical physical, mental, and psychosocial well-being.Explanation and Compliance Guidelines state:2. The facility, regardless of size, will provide medically related social services to each resident to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.3. The social worker, or social service designee, will complete an initial and quarterly assessment of each resident identifying any need for medically related social services. Any need for medically related social services will be documented in the medical record.4. The social worker, or social service designee, will pursue the provision of any identified need for medically related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline. Services to meet the resident's needs may include:f. Assisting with informing and educating residents, their family, and/or representative about health care options and their ramifications.R14 was originally admitted on [DATE] with last readmission on [DATE]. R14 has an activated POAHC and diagnoses including metabolic encephalopathy, seizures (on anticonvulsants), senile dementia, chronic obstructive pulmonary disease (COPD), asthma, acute kidney injury (AKI), anemia, hypothyroidism, hypertension, hyperlipidemia, hypotension, Type II diabetes mellitus, chronic pain, smoker, bipolar type 2, paranoid schizophrenia, anxiety, depression, dehydration, and bacteriuria.R14's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented interviews for cognition and mood/behaviors that were deferred to staff. The Brief Interview for Mental Status (BIMS) was 03, indicating severely impaired cognition, with R14 documented as speaking clearly and able to understand and be understood. No acute mental status changes or rejection of care were identified. R14 was assessed to be wheelchair dependent and required extensive assistance with activities of daily living, including dependent dressing and setup assistance for eating. R14 was identified to be at risk for skin breakdown with no pressure injuries or vascular wounds. The only intervention documented on the MDS section M was nutrition/hydration for skin management; pressure-reducing cushion, mattress, and turning/repositioning interventions were not documented. Prognosis indicated R14 did not have a condition or chronic disease expected to result in a life expectancy of less than six months.R14's Annual MDS assessment dated [DATE] documented no rejection of care and no altered mental status. Urinary continence declined to always incontinent, which was not addressed in the care plan or reassessed, and the care plan did not indicate a check and change program. R14's Mobility declined with increased assistance needed for bed mobility and transfers. R14 was assessed as having developed at least one Stage 2 pressure injury and three venous wounds. Interventions identified in section M included nutrition/hydration for skin, pressure injury care, non surgical dressings, and ointments other than to feet; pressure-reducing devices and turning/repositioning interventions were not documented. R14's prognosis remained unchanged from the 9/4/25 quarterly MDS. Discharge planning was noted; however, no referral was made despite anticipated discharge within three months or less.Nurse Practitioner (NP)-I documented a progress note on 12/23/25 with concerns of worsening wounds. An x-ray of the coccyx could not (continued on next page)

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	05/07/2026

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rule out osteomyelitis. R14 was experiencing decline and was pocketing food. The plan was to discuss and initiate hospice services with POAHC-CCC. (Cross-reference F684 and F686).NP-I documented a progress note on 12/24/25 noting concerns for osteomyelitis in the coccyx wound. NP-I documented R14 demonstrated significant swallowing difficulties. Diet was downgraded to mechanical soft with nectar thick liquids (nursing note and dietary request form documented the downgrade was to pureed with nectar thick liquids). NP-I documented POAHC-CCC was in agreement to transition to hospice services; however, interview with POAHC-CCC on 4/17/26 at 3:44 PM indicated they did not agree to hospice services and were not aware of wound infection or intake concerns.R14's medical record contained a Social Services note dated 12/3/25 by Social Worker (SW)-K (no longer at the facility), documenting: Resident to remain Long Term Care until alternate placement is found. Care plans reviewed and updated as needed. Surveyor noted R14 had been followed by Physiatry Assistant (PA)-J on a routine basis who was working with R14 on pain and strengthening in preparation of a possible transfer to the community. PA-J documented R14 was being discharged to an ALF (adult Family Home). There was no documentation or discharge planning from social services to indicate there was a discharge plan for R14. Surveyor was unable to locate any social services documentation after 12/3/25 in R14's medical record. Surveyor was unable to locate any documentation in R14's medical record regarding hospice referrals or communication about end-of-life care with POAHC-CCC by social services. On 4/16/26, at 3:15 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B, and Director of Operations (DOO)-O, Surveyor shared concerns regarding R14's social service documentation and hospice process.On 4/20/25, at 11:55 AM, NP-I and CNS-B met with Surveyor. NP-I and CNS-B confirmed POAHC-CCC did not sign an agreement for hospice while at the facility. NP-I provided CNS-B screenshots from her phone of text messages with a nurse for (name of hospice group) regarding contacting POAHC-CCC about hospice services. CNS-B shared the screenshots with Surveyor. POAHC-CCC did not sign contracts or provide any consent for R14 to receive hospice services or end of life care in lieu of treatment of R14. There was no documentation of POAHC-CCC being involved in discussing clinical changes and treatments, selection of potential hospice providers, and results of tests regarding R14. During interview on 4/20/26 at 11:55 AM, NP-I told Surveyors NP-I texted the hospice nurse that contacted POAHC-CCC. The hospice agency was selected by NP-I with no options provided to POAHC-CCC. NP-I proceeded with ordering and implementing end of life care and treatment without the consent of POAHC-CCC. Social Services was not involved in these discussions or referrals regarding R14's care and treatment.No additional information was provided.

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	05/07/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure the accurate and safe administration of medication for 1 resident (R28) of 3 reviewed. R28's Amlodipine Besylate 5mg (milligrams) medication for hypertension was unavailable and facility staff did not check contingency for the medication or notify R28's physician. Findings include:The Facility Policy and Procedure titled, Unavailable Medications, last revised 4/9/2025, documents: Guideline: The facility shall use uniform guidelines for unavailable mediations.Explanation and Compliance Guidelines:1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn, and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. (See Guideline: Medication Reordering.) 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold. 5. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication.The Facility checklist titled Resident's Meds Not Available Checklist, with no date, documents (in part): Medications Not Available- Did you.? Exhaust all efforts to locate medication in facility. Attempt to utilize CONTIGENCY to pull medications as able. Notify Pharmacy of medication needed and order STAT. DOCUMENT who you spoke with and what was discussed. Notify MD if unable to obtain medication, make note of available options in CONTIGENCY for potential alternatives. Obtain orders and DOCUMENT.R28 was admitted to the facility on [DATE] with pertinent diagnoses that include hypertension (high blood pressure), cerebral infarction (a type of ischemic stroke defined as the death of brain or retinal tissue due to a lack of oxygen (hypoxia) and restricted blood supply (ischemia)), dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), dysphagia (difficulty swallowing), and chronic kidney disease at stage 4 (severe kidney damage with an estimated glomerular filtration rate (eGFR) between 15 and 29 mL/min, representing the final stage before kidney failure). R28's Significant Change Minimum Data Set (MDS) with an assessment reference date of 3/11/2026, documents a Brief Interview for Mental Status (BIMS) score of 08, indicating R28 has moderate cognitive impairment. The MDS documents that R28 was assessed to have no behaviors exhibited during the look back period and is usually understood and usually understands others. R28's physician order dated 3/31/2026 documents Amlodipine Besylate Oral Tablet 5MG. Give 5mg by mouth in the morning for hypertension.R28's Medication Administration Record (MAR) documents that the 4/14/2026 dose of amlodipine besylate was not given.Surveyor observed medication administration for R28 on 4/14/2026, at 9:30 AM. Licensed Practical Nurse (LPN)-P could not locate R28's amlodipine besylate medication card. LPN-P stated the pharmacy was called at this time and stated the medication would be sent out that night.Surveyor noted that LPN-P did not utilize contingency medicatiosn to determine if the medication was at the facility. Surveyor noted that LPN-P did not call and update the physician about R28's missing medication. On 4/15/26, at 8:18 AM, Surveyor interviewed Unit Manager (UM)-T (continued on next page)

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	05/07/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding R28's missed dose of Amlodipine Besylate. Per UM-T, the facility does follow ups on missed medications the day after. Surveyor asked if the facility had contingency and was told they do however it is not the best. UM-T stated, tt is a mess and there is no list of medications available. Regardless, UM-T stated that LPN-P should have checked to see if the medication was available. Surveyor noted that the facility following up on missed medications the day after they were not administered could result in a negative impact for the resident due to delayed response from the physician.On 4/15/2026, at 3:30 PM, during the end of day meeting, Surveyor informed Clinical Nurse Specialist-B and Nursing Home Administrator (NHA)-A know of concern that R28's Amlodipine Besylate dose was missed and contingency was not checked for the medication and that R28's physician was not updated on the missed dose.No additional information was provided regarding R28's amlodipine besylate not being available for administration as ordered.

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	05/07/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility did not ensure the medication error rate was below 5% for 2 (R24 and R29) of 6 residents observed receiving medications. The facility medication error rate was 12%. *R29 received one 81mg enteric coated Aspirin. R29's physician order documents Aspirin 81 oral tablet chewable (aspirin). Give 81mg by mouth in the morning for NSTEMI.*R24 received one 81mg chewable Aspirin. R24's physician order documents Aspirin EC (enteric coated) tablet delayed release 81MG (aspirin). Give 1 tablet by mouth in the morning for heart disease. *R24 received Senna 8.6mg. R24's physician order documents Senna-Docusate Sodium oral tablet 8.6-50 mg (sennosides-docusate sodium). Give 1 tablet by mouth two times a day for constipation.Findings include:On 4/14/2026, at 8:49 AM, Surveyor observed medications being administered to R29. Licensed Practical Nurse (LPN)-R prepared six medications to administer to R29. Surveyor observed LPN-R add one 81 mg enteric coated Aspirin to the medication cup that R29 was to receive. Surveyor noted upon review of R29's physician orders the order for Aspirin documents Aspirin 81 oral tablet chewable (aspirin). Give 81mg by mouth in the morning for NSTEMI. Surveyor noted Chewable aspirin (uncoated) is designed for rapid absorption to treat acute pain or potential heart attacks, while enteric-coated aspirin passes through the stomach to reduce gastrointestinal irritation, offering delayed absorption for daily, long-term regimens. Chewable works in minutes, whereas enteric-coated takes hours, per the Mayo Clinic News Network website.On 4/14/2026, at 9:05 AM, Surveyor observed mediations being administered to R24. Registered Nurse (RN)-S prepared five medications to administer to R24. Surveyor observed RN-S add one 81mg chewable Aspirin to the medication cup that R24 was to receive. Surveyor noted upon review of R24's physician orders the order for Aspirin documents Aspirin EC (enteric coated) tablet delayed release 81MG (Aspirin). Give 1 tablet by mouth in the morning for heart disease.Surveyor noted Chewable aspirin (uncoated) is designed for rapid absorption to treat acute pain or potential heart attacks, while enteric-coated aspirin passes through the stomach to reduce gastrointestinal irritation, offering delayed absorption for daily, long-term regimens. Chewable works in minutes, whereas enteric-coated takes hours, per the Mayo Clinic News Network website.Surveyor also observed RN-S add one Senna 8.6mg to R24's medication cup. Surveyor noted upon review of the physician orders R24's order for Senna documents Senna-Docusate Sodium oral tablet 8.6-50 mg (sennosides-docusate sodium). Give 1 tablet by mouth two times a day for constipation.Surveyor noted Senna is a stimulant laxative that forces bowel movements, while Senna-Docusate (e.g., Senna S, Peri-Colace) combines that stimulant with a stool softener (docusate) for easier, less painful passage. Senna is better for acute, stubborn constipation, while the combination is superior for preventing constipation per the National Institute of Health website.On 4/15/2026, at 8:18 AM, Surveyor interviewed Unit Manager (UM)-T regarding the administration of Aspirin not per physician orders for R24 and R29 and the incorrect senna order being administered to R24. UM-T stated UM-T will provide education.On 4/15/2026, at 3:30 PM, during the end of day meeting, Surveyor informed Clinical Nurse Specialist-B and Nursing Home Administrator (NHA)-A know of concern that the medication error rate was 12% due to incorrect types of Aspirin being given to R24 and R29 and, R24 receiving the incorrect senna formulation. No further information was provided regarding the medication error rate being observed to be 5%.

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	05/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility did not ensure 13 (R13, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, & R27) of 13 sampled residents with scheduled medication administrations on 3/6/2026 from 7:00pm to 7:00am were free from significant medication errors.Findings include:The Facility Policy and Procedure titled, Medication Error Reporting and Counseling Procedure, last revised 4/9/2025, documents: Explanation and Compliance Guidelines:1. The facility shall ensure medications will be administered as follows:a. According to physician's orders.4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following:a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to:i. Incorrect dose, route, dosage form, time of administration;ii. Medication omission.8. If a medication error occurs, the following procedure will be initiated:a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible.b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions.c. Document actions taken in the medical record.Detailed Procedure After Medication Error:1. Reporting the Medication Error:a. The person who identifies a medication error should immediately report it to the charge nurse or the designated nursing supervisor and ultimately the Director of Nursing. When a medication error occurs, the licensed nurse/employee needs to be able to report the error, and without fear of penalty, to Nursing Management.b. Provide accurate, factual, and detailed information regarding the error by completing a Risk Management report. There is full transparency around medication errors to develop actions to correct the error and to prevent recurrence.2. Assessing and Documenting the Medication Error:a. A prompt assessment of the resident(s) involved to be completed to determine harm or the potential risks to the resident. Document all relevant details of the medication error in the resident's record and incident report (Risk Management).3. Notifying the Provider(s):a. The facility will inform the primary or prescribing physician(s) of the medication error in a timely manner and document notification in the medical record.5. Medication Error Counseling:a. The staff members involved in the medication error will complete a Medication Error Counseling form with the Director of Nursing or Designee. The error needs to be examined for causative factors including human error and system/procedure issues.7. Continuous Quality Improvement:a. The facility will conduct periodic reviews of medication errors through QAPI (Quality Assurance Performance Improvement) to identify recurring themes or patterns.Findings include:Surveyor was investigating a complaint alleging that residents located in the back part of the Sparkle unit did not receive medications after 7pm on March 6th, 2026. Surveyor reviewed the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for residents residing on the Sparkle unit for that shift. Surveyor noted that 13 residents had medications not marked as administered on their MAR. Surveyor noted that four residents on the unit did not have scheduled medications on the night shift, after 7pm, on 3/6/2026.On 4/15/2026, at 11:03am, Surveyor interviewed Unit Manager (UM)-T regarding the MAR/TAR for 3/6/2026 and medications not administered after 7pm. UM-T had not noticed this and will look into the issue. Surveyor asked if the physicians were called and UM-T stated no, because they did not know about the issue.On 4/15/2026, at 2:17pm, Surveyor discussed concern with Clinical Nurse Specialist-B regarding medications not being administered after 7pm on 3/6/2026. Clinical Nurse Specialist-B stated will look into but won't find anything because it was before Clinical Nurse Specialist-B got here to fix issues.On 4/16/2026, at 8:40am, Surveyor interviewed Agency Nurse-GG who stated their shift started at 7pm, they were on the front part of the Sparkle unit. Agency Nurse-GG remembers that there was not another nurse to cover the back part of the Sparkle unit until 11pm, none of the nurses working would stay late to cover the unit. On 4/16/2026, at 8:53am, Surveyor interviewed Licensed Practical Nurse (LPN)-W who stated they picked up a shift on 3/6/2026 and worked 11pm to 7am. There was another nurse on the front cart. No one was on the (continued on next page)

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	05/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back cart when LPN-W started the shift. Surveyor asked if LPN-W gave medications when they arrived that night. LPN-W stated all the medications were red as they were not given and it was past the administration time. Surveyor asked if LPN-W proceeded to give the medications and was told no, due to the time to be given, they should have been given earlier, they were late. Surveyor asked LPN-W if they contacted the physician and was told no, they notified the Assistant Director of Nursing and was told it was ok, so the physician was not notified.A review of the residents MAR on the Sparkle unit for March 6, 2026 after 7 PM noted that the following residents did not receive the following medications per physician orders:*R24 had the following medications scheduled for HS (at bedtime) on 3/6/2026 that were not marked as administered: Amlodipine besylate 10mg for hypertension, ammonium lactate external cream 12% for dry feet, melatonin 3mg for insomnia, and senna-docusate 8.6-50mg for constipation.R24's progress note dated 3/9/2026, written at 6:12pm documents: F/U (follow up) to 3/7 SBP (systolic blood pressure) 191. Nurse Practitioner was notified and no new orders placed. BP (blood pressure) this shift was 145/64. Surveyor noted the 3/7/26 blood pressure was taken in the morning following R24 missing the bedtime dose of amlodipine besylate 10mg. Surveyor noted amlodipine besylate 10mg is for elevated blood pressure which 191 for systolic blood pressure demonstrates.*R23 had the following medications scheduled for HS (at bedtime) on 3/6/2026 that were not marked as administered: Benadryl 25mg for allergies, gabapentin 100mg for neuropathy, Lantus insulin 10 units for diabetes mellitus 2 blood glucose management, metoprolol tartrate 125mg for hypertension, pravastatin 80mg for hyperlipidemia, and trazadone 25mg for insomnia. R23 had the medication amlodipine besylate 5mg scheduled for 5:00am on 3/7/2026 and it was not marked as administered. Surveyor noted LPN-W worked from 11pm to 7am. *R21 had the following medications scheduled for HS (at bedtime) on 3/6/2026 that were not marked as administered: atorvastatin calcium 80mg for hyperlipidemia, Lantus insulin 22 units for diabetes mellitus 2 blood glucose management. Metoprolol succinate 12.5mg for hypertension was scheduled for 9:00pm and gabapentin 200mg for neuropathy was scheduled for 8:00pm and neither were marked as administered. *R22 had the following medications scheduled for HS (at bedtime) on 3/6/2026 that were not marked as administered: Seroquel 50mg for bipolar disorder, acetaminophen 1000mg for pain, benztropine mesylate 1.5mg for Parkinson's, gabapentin 100mg for pain, levetiracetam 750mg for seizures, pramipexole dihydrochloride 0.125mg for restless leg syndrome, and senna plus 8.6-50mg for constipation.*R19 had ramelteon 8mg for insomnia scheduled at 8:00pm on 3/6/2026 that was not marked as administered. R19 had the following medications scheduled for 9:00pm that were not marked as administered: budesonide-formoterol fumarate inhaler for shortness of breath, levetiracetam 1500mg for prevention of seizure, and metoprolol tartrate 150mg (diagnosis not indicated).*R25 had carvedilol 12.5mg for heart health and Eliquis 5mg for blood clot prevention scheduled at 9:00pm on 3/6/2026 that were not marked as administered. R25 had baclofen 5mg for muscle spasms and gabapentin 300mg for pain management scheduled for 8:00pm and neither were marked as administered.*R26 had the following medications scheduled for HS (at bedtime) on 3/6/2026 that were not marked as administered: atorvastatin calcium 40mg for cholesterol, famotidine 20mg for acid indigestion, melatonin 5mg for insomnia, quetiapine fumarate 200mg for sleep/anxiety, dicyclomine HCl 20mg for irritable bowel syndrome, fiber laxative 1250mg for constipation, and pantoprazole sodium 40mg for GERD (Gastroesophageal Reflux Disease).*R20 had atorvastatin calcium 20mg for HDL (high-density lipoprotein cholesterol) and apixaban 2.5mg for nontraumatic subarachnoid hemorrhage scheduled for HS (at bedtime) on 3/6/2026 that were not marked as administered. R20 had mirtazapine 7.5mg for weight loss scheduled at 8:00pm that was not marked as administered. *R13 had melatonin 8mg for sleep deprivation and zyprexa zydis 5mg for schizophrenia scheduled at 8:00pm on 3/6/2026 that were not marked as administered. R13 had senna 8.6mg for constipation scheduled for 9:00pm that was not marked as administered. R13 had gabapentin 200mg for pain, famotidine 20mg for GERD (Gastroesophageal Reflux Disease), preservision areds 2 (supplement for eye health) and Tylenol 500mg for pain/fever scheduled for HS (continued on next page)

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	05/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(at bedtime) that were not marked as administered.*R18 had atorvastatin calcium 40mg for cholesterol that was scheduled at 8:00pm on 3/6/2026 that was not marked as administered. R18 had apixaban 5mg for blood thinner and pantoprazole sodium 40mg for GERD (Gastroesophageal Reflux Disease) that were scheduled for HS (at bedtime) that were not marked as administered.*R16 had apixaban 2.5mg for blood thinner that was scheduled at 9:00pm on 3/6/2026 that was not marked as administered.*R17 had the following medications scheduled for 8:00pm on 3/6/2026 that were not marked as administered: atorvastatin calcium 20mg for cholesterol, clonazepam 0.5mg for anxiety, escitalopram oxalate 10mg for anxiety, hydrocortisone 10mg (no diagnosis given), melatonin 9mg for sleep, ropinirole HCl 2mg for restless legs, and tamsulosin HCl 0.4mg (no diagnosis given).* R27 had melatonin 6mg for insomnia scheduled for HS (at bedtime) on 3/6/2026 that was not marked as administered.No additional information was provided as to why the facility did not ensure that above residents received medications on the night shift of 3/6/2026.

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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, drugs and biologicals used in the facility were not labeled in accordance with currently accepted professional principles, and include the resident name, opened on or expiration date when applicable for 1 of 1 medication carts reviewed. The medication cart on front Sparkle unit contained insulin pens that were not labeled with a resident name or dated of when the pens were opened.Findings include: The Facility policy titled Insulin Pen with Date Implemented of 04/09/2025, documents: Guideline: It is the guideline of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge.Explanation and Compliance Guidelines:1. Insulin pens contain multiple doses of insulin but are used for a single resident only.2. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date.3. If the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy.9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation.On 4/15/2026, at 8:36am, Surveyor observed Licensed Practical Nurse's (LPN)-Q's medication cart on the Sparkle front unit. Surveyor observed three insulin pens in a drawer without resident names or dates. On 4/15/2026, at 8:36am, Surveyor interviewed LPN-Q regarding the medications not being labeled with resident name or a date for when the insulin pens were opened or expire. Surveyor asked how staff would know which resident the insulin pens belong to and LPN-Q stated that staff don't know. On 4/15/2026, at 8:40am, Surveyor interviewed Unit Manager (UM)-T about the pens not being labeled appropriately. UM-T and Surveyor went out to the cart and removed the insulin pens from the cart. On 4/15/26, at 3:30pm, during the end of day meeting, Surveyor informed Clinical Nurse Specialist-B and Nursing Home Administrator-A know of concern that the medication cart on Sparkle Front unit had insulin pens that were not labeled with the resident name or date of when the insulin pens were opened and or expire. No additional information was provided as to why the facility did not ensure that opened insulin pens were labeled according to professional principles.

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	05/07/2026

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a resident's change in diet consistency was comprehensively assessed, including obtaining supporting physician or Registered Dietician documentation, after a change in condition for 1 (R14) of 6 residents reviewed for nutrition.*R14's diet was downgraded from a mechanical soft ground diet with thin liquids to a pureed diet with nectar thick liquids without evidence of a comprehensive assessment related to the change in condition. There was no physician order or Registered Dietitian order regarding the diet downgrade.Findings include:The facility's policy and procedure Therapeutic Diet Orders revised 3/26/2025. The Guideline: The facility provides all residents with foods in the appropriate form and order the appropriate nutrient content as prescribed by a physician, and or assessed by the interdisciplinary team to support the resident's treatment plan of care, in accordance with his or her goals and preferences.Explanation and Compliance Guidelines:1. Each resident nutritional status is assessed by the interdisciplinary team in accordance with assessment policies.2. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to:a. Inadequate nutritionb. Nutritional deficitsc. Weight lossd. Medical conditions such as diabetes, renal disease, or heart diseasec. Swallowing difficulty3. Therapeutic diets are provided only when ordered by the attending physician or a registered or licensed dietitian who has been delegated to write diet orders, to the extent allowed by state law. Should the attending physician delegate the prescribing of therapeutic diets he or she will supervise the dietician and remain responsible for the resident care.4. The reason for a therapeutic diet is to be documented in the medical record and/ or indicated on the resonance comprehensive plan of care period all diet orders are to be communicated to the dietary department in accordance with facility procedures.R14 was readmitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, seizures (on anticonvulsants), senile dementia, COPD (chronic obstructive pulmonary disease), asthma, AKI (acute kidney disease), anemia, bipolar type 2, paranoid schizophrenia, anxiety, depression, dehydration and Bacteriuria.R14's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R14 required setup assistance for eating. R14's Annual MDS dated [DATE] also documented R14 required set up assistance for eating. R14's Nutrition Care Plan dated 12/9/24 documented the resident was at risk for nutritional imbalance related to obesity due to good intake and a sedentary lifestyle, as evidenced by a BMI (body mass index) greater than 30, and a mechanically altered diet due to dysphagia as evidenced by a mechanical soft diet. Additional risks included potential weight fluctuations due to fluid shifts and impaired skin integrity with unstageable pressure injuries to the coccyx (x2) and vascular wounds to the left and right first metatarsal heads. The care plan was initiated 12/2/25 and revised 12/22/25.Goals included preventing complications related to obesity such as skin breakdown, impaired breathing pattern, altered cardiac output, diabetes, and impaired mobility through review date, with a target date of 3/10/26. A second goal was to maintain adequate nutritional status as evidenced by no significant weight changes, no signs or symptoms of malnutrition, and intake greater than 75% of estimated needs through review date, with a target date of 3/10/26.Interventions included administering medications as ordered and monitoring for effectiveness and side effects (initiated 3/3/25); monitoring and reporting signs and symptoms of dysphagia including pocketing, choking, coughing, drooling, food holding, repeated swallowing attempts, refusal to eat, or distress during meals (initiated 12/9/24); obtaining and reporting laboratory/diagnostic results to the physician as indicated (initiated 3/3/25); and providing a bedtime snack of yogurt (initiated 11/19/25).R14's December 2025 Treatment Administration Record (TAR) documents physician orders to monitor every shift for pocketing food. This is documented every shift (continued on next page)

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	05/07/2026

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as not occurring. R14's nursing note dated 12/23/25 completed by Licensed Practical Nurse (LPN)-EEE documents: (R14) is pocketing food and diet was downgraded to pureed with nectar liquids. There is no documentation that an assessment was completed for the change in R14's diet consistency or that an order was obtained for the diet downgrade. On 4/15/26, at 10:15 AM, Surveyor interviewed Registered Dietitian (RD)-G. RD-G documented a nutritional assessment was completed for R14 on 12/22/26 with no nutritional changes and noted that R14's intake was good. RD-G informed Surveyor that RD-G was not aware of any eating concerns or diet changes for R14.On 4/15/26, at 10:45 AM, Surveyor interviewed Director of Rehabilitation (DOR)-FF. DOR-FF reviewed R14's therapy notes during this interview. DOR-FF informed Surveyor that R14 had not received any therapy services since 10/2/25 and that R14 did not have a referral, or assessment, for speech therapy with a change in diet with swallowing changes.On 4/15/26, at 1:22 PM, Surveyor interviewed Food Service Director (FSD)-M. FSD-M informed Surveyor that the kitchen does not change a resident's diet until they get a Diet Change Form. FSD-M informed Surveyor that once the kitchen received a Diet Change Form, the kitchen will change the meal ticket. FSD-M provided a Diet Change Form for R14 dated 12/23/25 for pureed consistency and nectar thick liquids.On 12/24/25 Nurse Practitioner (NP)-I documented a progress note that indicated: Concerns with osteomyelitis in the coccyx wound, (R14) now displays significant swallowing difficulties. Diet was downgraded to mechanical soft with nectar liquids.Surveyor noted that R14's nursing note, and dietary request form, documented the change was supposed to be a downgrade from mechanical soft with thin liquids to pureed with nectar thickened liquids. NP-I noted the change however, an order was not given for the consistency change or assessment of R14's swallowing. Surveyor noted there were no revisions to R14's plan of care for the change on 12/23/25 for a pureed diet with nectar thickened liquids. On 4/16/26, at 3:15 PM, during the facility exit meeting with Nursing Home Administrator (NHA)-A, Clinical Nurse Specialist (CNS)-B, and Director of Operations (DOO)-O Surveyor shared the concerns related to R14's diet change and the lack of an assessment related to the downgrade in diet consistency. Clinical Nurse Specialist (CNS)-B stated nursing staff could initiate a diet downgrade; however, the resident should then be referred to Speech Therapy for an assessment.On 4/20/25, at 11:55 AM, NP-I and CNS-B met with Surveyor. NP-I informed Surveyor she believed she had given verbal orders to change R14's diet order. There was no documentation in R14's record to support an order was given for the change in R14's diet. No additional information was provided.

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	05/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not implement an effective infection control program, including surveillance of infections in the facility, and sanitizing equipment. This had the potential to affect all 105 residents in the facility. The facility did not have documentation of facility infection surveillance for January, February and March of 2026. * R20 received blood glucose sampling through an un-sanitized glucometer machine. Findings include: The facility's policy and procedure Infection Surveillance revised 5/29/2024 documents: Policy: Infection surveillance services. There's a core activity of the Facilities Infection Prevention and Control Program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.Policy Explanation and Compliance Guidelines:1.The infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and report surveillance findings to the Facilities Quality Assessment and Assurance Committee, in public health authorities when required. The facility's policy and procedure Infection Prevention and Control Program revised 2/5/2025. Policy: This facility established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. As per accepted national standards and guidelines.Explanation and Compliance Guidelines:3. Surveillance:a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards.b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance binding to the Facilities Quality Assessment and Assurance Committee.c. The RN's and LPN'S participate in surveillance through assessment of residents and reporting changes in condition to the resident's physician and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. 1.) On 4/14/26, at 3:20 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Clinical Nurse Specialist (CNS) -B and Director of Operations (DOO)-O, Surveyor asked for the facility Infection Preventionist (IP). The facility has had changes in staff and CNS-B, and DOO-O are covering that role. Surveyor requested for the last 6 months of facility infection surveillance documentation. On 4/15/26, at 2:00 PM, Surveyor interviewed DOO-O. DOO-O provided surveillance documentation for November 2025, December 2025 and April 2026. The Surveillance documentation could not be located for March 2026. The January and February 2026 documentation was not documented into the surveillance form. There was no documentation of infection surveillance for January, February and March 2026. The IP responsible during this period is no longer at the facility. (continued on next page)

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	05/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted that the facility did not have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. On 4/16/26, at 3:15 PM, at the facility exit meeting with NHA-A, CNS-B and DOO-O, surveyor shared the concerns with the facility surveillance documentation. No additional documentation was provided. The facility's policy and procedure titled, Glucometer Cleaning & Disinfection date reviewed 10/07/2025, documents: Guideline: The purpose of this procedure is to provide expectations for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Explanation and Compliance Guidelines1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to the manufacturer's instructions for multi-resident use.3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus.4. Glucometers will be cleaned and disinfected, stored in clean area, Ziplock or individual/labeled case, after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use.5. Procedure recommendations.i. Retrieve (2) disinfectant wipes from container.j. If visible soiled/dirty, proceed with cleaning step. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer.k. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry.l. Discard disinfectant wipes in waste receptacle. 2.) R20 was admitted to the facility on [DATE] with pertinent diagnoses of type 2 diabetes mellitus. R20's Annual Minimum Data Set (MDS) with an assessment reference date of 4/13/2026, documents that a Brief Interview for Mental Status (BIMS) was not completed because the resident is rarely/never understood. The MDS documents R20 was assessed to have no behaviors exhibited during the look back period and is usually understood and usually understands others. The MDS documents that a hypoglycemic (including insulin) was administered to R20 during the assessment period. R20's physician order dated 12/4/2025, documents: Immunodeficiency monitor for any signs/symptoms of: fever, redness, drainage, or swelling around wounds, catheters, or vascular sites, cough, respiratory symptoms, dysuria, hematuria, flank pain, and or foul smelling urine. One time a day for type 2 diabetes mellitus with diabetic/immunodeficiency. R20's physician order dated 1/22/2026, documents: Insulin aspart injection solution, inject as per sliding scale. Surveyor noted the blood glucose is recorded in addition to the amount of insulin given. On 4/15/2026, at 7:57am, Surveyor observed Licensed Practical Nurse (LPN)-U wipe the glucometer with an alcohol wipe pad. LPN-U then proceeded to obtain R20's blood glucose. After this, LPN-U wiped the glucometer with an alcohol wipe pad again and put the glucometer in the cart drawer. (continued on next page)

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	05/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/15/2026, at 8:09am, Surveyor interviewed LPN-U and asked if the glucometer was for individual residents or shared and LPN-U informed Surveyor that the glucometer is shared by the residents on the unit. Surveyor asked what the cleaning procedure was. LPN-U informed Surveyor that LPN-U uses an alcohol wipe pad unless there are wipes available, if there is, then LPN-U will use those. On 4/15/2026, at 8:18am, Surveyor interviewed Unit Manager (UM)-T about the glucometers and was told each cart has 2, they are not assigned to individual residents. Surveyor discussed LPN-U wiping with alcohol wipe pad between residents and not cleaning the glucometer with the correct disinfectant. On 4/15/2026, at 3:30pm, during the end of day meeting, Surveyor let Clinical Nurse Specialist-B and Nursing Home Administrator (NHA)-A know of concern that the glucometer on the back area of the Sparkle unit was not cleaned with the proper disinfection process between residents. No additional information was provided regarding the use of an unsanitized glucometer for blood glucose sampling.

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	05/07/2026

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not offer the influenza immunization to 1 (R4) of 1 residents reviewed for immunizations.*R4 requested the influenza vaccine in [DATE], and has not received a influenza vaccine as of April of 2026.Findings Include:The facility's policy titled, Influenza Vaccination dated as last revised on [DATE] documents: Influenza vaccinations will be routinely offered annually from [DATE]st to [DATE]st unless such immunizations is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine.Additionally, influenza vaccinations will be offered to residents upon availability of the seasonal vaccine until influenza is no longer circulating in the facility's geographic area.Flowing the assessment for potential medical contraindications, influenza vaccinations may be administered in accordance with physician-approved standing orders.Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent from prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record or the staff's medical file.In case of lack of availability of the influenza vaccine, or other issue with the availability leading to an inability to implement the influenza vaccine program, the facility will demonstrate:The vaccine has been ordered and the facility received either the vaccine or a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is availablePlans are developed on how and when the vaccines are to be administered. Residents have been screened to determine how many and which residents are eligible and wish to revive the vaccine; and education regarding immunizations program should be directed to chief nursing officer.R4 was admitted to the facility on [DATE] with diagnoses that include End Stage Renal Disease (Permanent Kidney failure requiring dialysis or a kidney transplant), Dependence on Renal Dialysis (treatment that filters waste and excess fluids), Type 2 Diabetes (the body does not produce insulin causing high blood sugars), Asthma (chronic lung disease causing difficulty breathing), and Chronic Respiratory Failure with hypoxia (chronic condition where lungs cannot transfer enough oxygen into the blood).On [DATE], at 9:50 AM, Surveyor reviewed R4's Electronic Medical Record (EMR). Surveyor was unable to locate any information pertaining to R4 being offered or receiving the influenza vaccination. There was no documentation that R4 received education regarding the benefits and potential side effects of receiving or declining the influenza immunization. There was no documentation in R4's medical record that R4 was offered, declined or received the influenza immunization.R4's progress note dated [DATE], at 5:54 AM, documented: R4 is own person - elected to receive both the Flu and Covid vaccine for this upcoming year. Consents filled out appropriately. All needs met at this time.Surveyor was unable to locate any documentation that R4 was offered, declined or received the influenza immunization after R4 elected to receive the influenza vaccine on [DATE].On [DATE], at 12:28 PM, Surveyor informed Clinical Nurse Specialist (CNS)-B, Director of Operations (DOO)-O, and Nursing Home Administrator (NHA)-A that R4 consented to have influenza vaccine and Covid vaccine and did not receive either vaccine. DOO-O reviewed R4's record and stated R4 declined the Covid vaccine but did want the influenza vaccine. DOO-O confirmed that R4 did not receive the influenza vaccine. DOO-O stated R4 should have received the influenza vaccine.No additional information was provided.

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	05/07/2026

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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility did not ensure that 5 out of 5 direct care staff reviewed received the required communication training. CNA (Certified Nursing Assistant) TT, UU, VV, WW, XX have all worked at the facility for longer than 1 year and have not received the required training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as last revised 1/1/25 and titled Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor reviewed 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their annual performance reviews and required resident right's training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received the required communication training. On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of communication training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee, per policy who is maintaining a training schedule and a documentation system for completed trainings.No additional information was provided.

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	05/07/2026

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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview and record review, the facility did not ensure that 5 out of 5 direct care staff reviewed, received the required resident rights training. CNA (Certified Nursing Assistant)TT, UU, VV, WW, XX have all worked at the facility for longer than 1 year and have not received the required training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as last reviewed 1/1/25 and titled, Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor reviewed 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their required resident rights training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024.The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received the required resident rights training.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of resident rights training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee, per policy who is maintaining a training schedule and a documentation system for completed trainings.No additional information was provided.

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	05/07/2026

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility did not ensure that 5 out of 5 direct care staff reviewed, received the required training regarding abuse, neglect and exploitation. CNA (Certified Nursing Assistant)TT, UU, VV, WW, XX have all worked at the facility for longer than 1 year and have not received the required training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as last reviewed 1/1/25 and titled Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor reviewed 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their annual performance reviews and required training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024.The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received training on abuse, neglect and exploitation.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of abuse, neglect and exploitation training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee, per policy who is maintaining a training schedule and a documentation system for completed trainings.No additional information was provided.

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	05/07/2026

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review the facility did not ensure that 5 out of 5 direct care staff reviewed received the required QAPI (Quality Assurance and Performance Improvement) training. CNA (Certified Nursing Assistant)TT, UU, VV, WW, XX all worked at the facility for longer than 1 year and have not received the required training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as revised 1/1/25 and titled, Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor reviewed 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their annual performance reviews and required training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024.The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received the QAPI training.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of QAPI training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee, per policy who is maintaining a training schedule and a documentation system for completed trainings.No additional information was provided.

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	05/07/2026

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interview and record review the facility did not ensure that 5 out of 5 direct care staff reviewed received the required training regarding infection control practices. CNA (Certified Nursing Assistant)TT, UU, VV, WW, XX have all worked at the facility for longer than 1 year and have not received the required training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as revised 1/1/25 and titled, Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor reviewed 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their annual performance reviews and required training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024.The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received infection control training.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of infection control training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee who is maintaining a training schedule and or documentation for completed trainings. No additional information was provided.

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	05/07/2026

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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based on interview and record review the facility did not ensure that 5 of 5 direct care staff reviewed received the required training regarding compliance and ethics.CNA (Certified Nursing Assistant) TT, UU, VV, WW, XX have all worked at the facility for longer than 1 year and have not received the required training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as last revised 1/1/25 and titled Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor chose 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their annual performance reviews and required training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024.The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received training regarding compliance and ethics.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of compliance and ethics training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee who is maintaining a training schedule and or documentation for completed trainings. No additional information was provided.

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	05/07/2026

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility did not ensure that 5 out of 5 Certified Nursing Assistants completed 12 hours of required training annually. CNA (Certified Nursing Assistant)TT, UU, VV, WW, XX have all worked at the facility for longer than one year and have not completed the required annual 12 hours of training. This has the potential to affect all 112 residents as the 5 staff members work on various units throughout the facility.Findings include:The facility's policy dated as revised 1/1/25 and titled Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.7. It is the responsibility of each employee, volunteer, or contract staff to complete required training. a. the facility offers a variety of training methods and times to accommodate individuals. b. An individual's failure to complete required training in a timely manner will result in termination of employment or contractual/volunteer status. 10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor chose 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor chose the following staff to review their annual performance reviews and required training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024.The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had completed 12 hours of required trainings annually.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of the 12 hours of annual training being completed. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee who is maintaining a training schedule and or documentation for completed trainings. No additional information was provided.

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	05/07/2026

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and record review, the facility did not ensure that 5 out of 5 direct care staff reviewed received the required behavioral health training.*CNA (Certified Nursing Assistant)TT, UU, VV, WW, XX have all worked at the facility for longer than 1 year and have not received the required behavioral training.This has the potential to affect all 112 residents as the 5 staff members work on various units of the facility.Findings include:The facility's policy dated as implemented 7/10/24 and revised 1/1/25 and titled Training Requirements documents: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 1. The facility has designated the Staff Development Coordinator, or designee, as the contact person for the facility's training program. The person works closely with the Compliance Officer and other facility leaders in developing the program. 2. The amount and types of training necessary are based on a facility assessment. 3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with their expected roles.6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. d. Written standards, policies and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health. g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention. i. Safety and emergency procedures.10. Documentation of required training will be forwarded to the HR (human resources) Department to be placed into the individual's personnel file, in accordance with facility policy for retention of training records. On 5/4/26, Surveyor randomly reviewed 5 Certified Nursing Assistants (CNA) from a list of employees provided by the facility. Surveyor review their annual performance reviews and required training.CNA- TT was hired on 12/4/2024CNA- UU was hired on 10/30/2024CNA- VV was hired on 12/4/2024CNA- WW was hired on 5/7/2024CNA- XX was hired on 10/30/2024The facility was unable to provide evidence that CNA-TT, CNA-UU, CNA-VV, CNA-WW and CNA-XX had received the required behavioral health training.On 5/5/26 at 9:45 AM, Surveyor interviewed HR (Human Resources) Director-YY who stated that after an employee is hired, HR Director-YY is responsible for all of the new-employee on-boarding and does not have anything to do with any of the annual trainings after the initial hire. HR Director-YY informed Surveyor that annual training should all be kept track of by nursing and that there is currently no Nurse Educator or Staff Development Coordinator.On 5/5/26, Surveyor interviewed Nursing Home Administrator- AAA and Director of Operations- O who both confirmed the facility did not have any evidence of behavioral health training being provided to staff. Nursing Home Administrator- AAA stated that all of the training records are in boxes that were kept by the previous Director of Nursing, and they have nothing organized for employee trainings. Nursing Home Administrator- AAA confirmed that there is no Staff Development Coordinator/ Designee who is maintaining a training schedule and or documentation for completed trainings. No additional information was provided.