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	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Suites at Oak Creek (the)	2700 Honadel Boulevard Oak Creek, WI 53154

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop an Activities of Daily Living (ADL) comprehensive plan of care for 1 (R1) of 3 residents reviewed for plans of care. Findings include:The facility policy with a last reviewed date of 5/1/25 and titled, Comprehensive Care Plans, documents, in part: It is the guideline of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive [Minimum Data Set (MDS)] assessment. The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.R1 was admitted to the facility on [DATE] with diagnosis that include heart failure (a chronic condition where the heart muscle cannot pump blood efficiently to meet the body's need), Local infection of the skin (invasion of the skin and underlying soft tissue by bacteria), Chronic respiratory failure (a long-term condition where the respiratory system cannot properly oxygenate the blood or remove carbon dioxide), abnormalities of gait and mobility (any irregular walking patter, such as limping, shuffling or feeling unsteady), and need for assistance with personal care(a diagnosis used when a patient requires help with daily living activities). R1's admission MDS assessment dated [DATE] documents R1 is cognitively intact. R1 requires staff assist with set up and cleaning for eating and hygiene. R1 is dependent on staff for dressing. R1 requires substantial/maximal assistance for shower/bathing. R1 is dependent on staff for toileting and transfers. Surveyor reviewed R1's Comprehensive care plan and Certified Nursing Assistant (CNA) Kardex for information on R1's Activity of Daily Living (ADL)'s. Surveyor noted the facility did not have an ADL care plan or information on the CNA Kardex that would inform staff on what assistance R1 would need with: bathing/showering, bed mobility, dressing, eating, toileting, hygiene and transfer. On 5/19/26 at 8:16 AM, Surveyor interviewed CNA-I. Surveyor asked how CNA-I would know what assistance a resident would need with bathing, dressing, eating, toileting and transfers. CNA-I stated that information like that is in the CNA Kardex. On 5/19/26 at 10:02 AM, Surveyor interviewed Unit Manager (UM)-J and Director of Nursing (DON)-B. Surveyor asked how staff would know what assistance a resident would need with bathing, eating, toileting and transfers. UM-J stated that the CNA Kardex and the Care Plan has that information on it. Surveyor informed UM-J and DON-B of the concern that R1 does not have an ADL care plan or any information on the CNA Kardex about R1's ADLs. DON-B stated that they will look at that immediately.On 5/19/26 at 11:39 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the above concerns. No further information was provided.

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

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

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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 interview and record review the facility did not provide the necessary Activities of Daily Living (ADL) services for 1 (R1) of 2 residents who were dependent on staff to provide ADL care.R1 is dependent on staff for showering and was admitted to the facility on [DATE]. On 5/18/26, R1 informed Surveyor that R1 has not received a shower since admission. Facility staff have not documented that R1 has received a shower since admission. R1 has not been bathed weekly according to the facility policy. Findings include:The facility policy with a last reviewed date of 6/11/25 and titled, Resident Showers, documents, in part: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided with showers as per request and within reasonable accommodation, or as per facility schedule protocols (at least offered weekly) and based upon resident safety. Partial baths may be given between regular shower schedules as per facility policy.R1 was admitted to the facility on [DATE] with diagnosis that include heart failure (a chronic condition where the heart muscle cannot pump blood efficiently to meet the body's need), Local infection of the skin (invasion of the skin and underlying soft tissue by bacteria), Chronic respiratory failure (a long-term condition where the respiratory system cannot properly oxygenate the blood or remove carbon dioxide), abnormalities of gait and mobility (any irregular walking patter, such as limping, shuffling or feeling unsteady), and need for assistance with personal care(a diagnosis used when a patient requires help with daily living activities). R1's admission MDS assessment dated [DATE] documents R1 is cognitively intact. R1 requires staff assist with set up and cleaning for eating and hygiene. R1 is dependent on staff for dressing. R1 requires substantial/maximal assistance for shower/bathing. R1 is dependent on staff for toileting and transfers. When asked how important is it to you to choose between a tub bath, shower, bed bath or sponge bath, R1 answered Very Important.On 5/18/26 at 8:45 AM, Surveyor interviewed R1. R1 informed Surveyor that R1 has not had a shower since being at the facility. R1 stated R1 had been at the facility for about a month. Surveyor asked why R1 did not receive a shower. R1 stated R1 did not know why. R1 stated that R1 has been asking for a shower but still has not had one. R1 stated that R1 has only been cleaned with wipes. R1 stated that showers relax R1 and R1 sleeps better after showers. Surveyor asked when R1's shower day is. R1 asked Surveyor, how would I know if they didn't tell me. Surveyor asked if R1 refused a shower. R1 stated No.Surveyor reviewed R1's Comprehensive care plan and Certified Nursing Assistant (CNA) Kardex and noted the facility did not have an intervention listed related to R1's shower day or preference.R1's MD order with a start date of 4/22/26 documents: Check vital signs and edema weekly with shower day. Every day shift every Wednesday for monitoring.Surveyor noted Wednesday is listed as R1's shower day.On 5/18/26 at 11:15 AM, Surveyor interviewed CNA-K. Surveyor asked how CNA-K would know when a resident's shower is supposed to take place. CNA-K stated that the information is kept in the binder at the nurse's station. CNA-K showed Surveyor the binder and flipped to the page that has the shower schedule. CNA-K stated that each resident room is listed and has a weekday, and shift associated with them to indicate what day and what shift the resident shower would take place. CNA-K pointed to R1's room number and indicated that R1's shower day is Wednesday on the overnight (noc) shift. Surveyor asked where showers are documented. CNA-K stated that there are shower sheets that are filled out and given to the nurse. The CNA and the nurse sign the sheet after the shower and skin check is completed. The sheets are placed in the file or the binder at the nurse's station.Surveyor reviewed the binder and file at the nurse's station. Surveyor noted multiple shower sheets in the file. The shower sheets go back as far as 4/2/26. Surveyor went through the pile and noted R1 did not have a completed shower sheet in the file. Surveyor reviewed the binder and did not observe a completed shower sheet for R1.On 5/19/26 at 8:16 AM, Surveyor interviewed CNA-I. Surveyor asked how staff know when a resident needs a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower. CNA-I stated they have a schedule that is listed at the nurse's station. CNA-I stated that showers are done once or twice a week and residents are split up between day, evening and night shift. Surveyor asked where showers are documented. CNA-I stated that showers are documented in the electronic health record (EHR) in the CNA task section. CNA-I stated that they document whether the resident gets a shower or bed bath. Surveyor reviewed R1's CNA task section in R1's EHR from the start of R1's admission to the facility. R1's Bathing task documented the following:4/28/26- Bed Bath.5/4/26- Bed Bath.5/6/26-Bed Bath.5/7/26-Bed Bath.Surveyor noted R1 went from 4/17/26 until 4/28/26 (10 days) without documented bathing. Surveyor noted R1 went from 5/7/26 until present time, 5/19/26 (11 days) without documented bathing. Surveyor noted that according to the facility documentation, R1 only received bed baths and did not receive a shower, which is R1's preference, since admission.Surveyor reviewed R1's progress notes and noted facility staff did not document a refusal of shower or bathing since R1's admission to the facility.On 5/19/26 at 8:28 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-L. Surveyor asked if nurses have a role in completing resident showers. LPN-L stated that nurses do not give showers but will complete skin checks at the time of shower. LPN-L stated that each resident has a designated shower time and day. Surveyor asked if residents complained about not getting showers. LPN-L stated that some residents will ask for a shower or tell LPN-L that they have not had a shower in a while. LPN-L will inform the CNA but if it is not the residents shower day, it is hard to get the shower completed. LPN-L stated that LPN-L will tell residents that they need to be firm and tell the CNA on their shower day that they want a shower so that is not missed. On 5/19/26 at 10:02 AM, Surveyor interviewed Unit Manager (UM)-J and Director of Nursing (DON)-B. Surveyor asked about the facility shower policy. UM-J stated that showers are given once a week and as needed. Staff can accommodate residents if they ask for a shower. UM-J stated that the CNA will fill out a shower sheet and the nurse will complete the skin check and sign the shower sheet. The shower sheets are kept. Surveyor asked if showers are documented in the EHR. UM-J indicated that CNAs should document that a shower was given in the task section of the EHR. Surveyor informed UM-J and DON-B of the concern that R1 informed Surveyor that R1 had not received a shower, which is R1's preference, since admission. R1 was unaware of R1's shower day, Wednesday night shift. In addition, Surveyor reviewed the task section of R1's EHR and the pile of completed shower sheets. Surveyor found R1 has not had a documented shower since admission and has not been bathed weekly per facility policy. DON-B stated that they will figure out what happened, talk to R1 and offer a shower. DON-B indicated they will also speak with R1 to make sure the time and day of R1's shower schedule will work for R1.On 5/19/26 at 11:39 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the above concerns. No further information was provided.

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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 observation, interview and record review, the facility did not ensure 1 (R1) of 3 residents received the necessary services for acceptable nutrition.*R1 did not have a comprehensive nutritional assessment on admission that included how R1 chews food. Facility staff did not identify that R1 is missing all R1's upper teeth and multiple lower teeth. R1's nutrition care plan did not document interventions related to R1's difficulty in chewing certain foods. R1 had an MD order for weekly weights. Facility staff did not weigh R1 weekly as ordered.Findings include: The facility policy, with a last reviewed date of 4/8/26, and titled, Nutritional Management, documents, in part: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. A systematic approach is used to optimize each resident's nutritional status. Identifying and assessing each resident's nutritional status and risk factors. Evaluating/analyzing the assessment information. Developing and consistently implementing pertinent approaches. Monitoring the effectiveness of interventions and revising them as necessary. Interventions will be individualized to address the specific needs of the resident. Examples include but are not limited to: . Altered-consistency food/liquids after underlying causes of symptoms are addressed (i.e. new dentures, dental consult, dysphagia therapy). Weight-related interventions. Informed consent: the resident/representative has the right to choose and decline interventions designed to improve or maintain nutritional or hydration status. The facility shall discuss the risks and benefits associated with the resident/representative decision and offer alternatives, as appropriate. The comprehensive care plan should describe any interventions offered, but declined by the resident or resident's representative.The facility policy, with a last reviewed date of 12/2/25, and titled, Weight Monitoring, documents, in part: 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 preferences indicate otherwise. A weight monitoring schedule will be developed upon admission for all residents: Weights should be recorded at the time obtained. Newly admitted residents- monitor weight weekly for 4 weeks.R1 was admitted to the facility on [DATE] with diagnosis that include heart failure (a chronic condition where the heart muscle cannot pump blood efficiently to meet the body's need), Local infection of the skin (invasion of the skin and underlying soft tissue by bacteria), Chronic respiratory failure (a long-term condition where the respiratory system cannot properly oxygenate the blood or remove carbon dioxide), abnormalities of gait and mobility (any irregular walking patter, such as limping, shuffling or feeling unsteady), and need for assistance with personal care(a diagnosis used when a patient requires help with daily living activities). R1's admission MDS assessment dated [DATE] documents R1 is cognitively intact. R1 requires staff assist with set up and cleaning for eating. R1 has no complaints of difficulty or pain when swallowing. R1 does not have broken or loosely fitting full or partial denture. On 5/18/26 at 1:15 PM, Surveyor observed R1 trying to eat the facility provided fruit. R1 informed Surveyor that R1 does not typically eat the facility food. R1 prefers food that family brings in or R1 will order food. R1 stated that R1 thought the hot apples would be good to eat but stated that R1 is unable to chew them and they are too hard. R1 stated that R1 had lost R1's dentures a while ago before being admitted to the facility. R1 stated that chewing with no teeth can be difficult. Surveyor asked if facility staff had addressed the fact that R1 does not have R1's dentures. R1 stated no. R1's MD order with a start date of 4/20/26 documents: Regular diet, regular texture, thin consistency.R1's potential for nutritional risk care plan, dated 4/23/26, [related to] obesity, [heart failure], [history left lower extremity] cellulitis and edema. Pertinent interventions include: Administer medications as ordered. Monitor intake of outside food. Monitor/document/report [as needed] any [signs or symptoms] of dysphagia. Provide and serve diet as ordered. Encourage intake (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of facility meals. [Registered dietician] to evaluate and make diet change recommendations [as needed].Surveyor noted that R1's nutritional care plan does not address R1's dentation and does not address if any other diet texture was offered.R1's admission Head-to-toe evaluation dated 4/17/26 documents, in part: Does the resident wear dentures? No.Surveyor noted facility staff documented that R1 does not wear dentures but does not address the fact that R1 used to have dentures that R1 no longer has. R1's Nutritional note dated 4/22/26 documents, in part: [R1] admits for rehab post hospitalization for [left lower extremity] cellulitis [with] sepsis. Receives regular diet which is appropriate. Reports appetite is good. Eats [independently without] vision concerns interfering [with] meals. No [chewing/swallowing] concerns reported. Surveyor noted that the admission nutritional note documents that R1 did not report any chewing or swallowing concerns, but Surveyor noted facility staff had no other documentation of R1's dentation which has the potential to affect R1's nutritional intake. Surveyor noted that facility staff did not offer a soft texture diet or discuss the risk and benefits of R1's diet related to R1's dentation.R1's Admit Visit Note dated 5/4/26 at 4:03 PM, documents, in part: . Patient unable to chew pills due to lack of teeth.Surveyor noted that R1's provider noted that R1 is unable to chew pills because of R1's dentation. Surveyor noted that this is the only documentation found about R1's dentation.On 5/19/26 at 8:16 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I. Surveyor asked if R1 had ever informed CNA-I of chewing difficulty. CNA-I stated that R1 has stated that it is hard to chew because R1 doesn't have many teeth. Surveyor asked what is done for R1's chewing problems. CNA-I stated that the facility has dentist come occasionally but CNA-I was not sure if R1 has had anything done about R1's teeth.On 5/19/26 at 8:28 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-L. Surveyor asked who assesses the resident's dentation status on admission. LPN-L stated the nurse will do the admission assessment and will document things like if the resident has a full or partial dentures. Surveyor asked what is done if a resident does not have their dentures. LPN-L stated that LPN-L would tell the unit manager. LPN-L would also talk to the resident's MD and talk about getting a pureed/soft diet temporary order.On 5/19/26 at 10:02 AM, Surveyor interviewed Unit Manager (UM)-J and Director of Nursing (DON)-B. Surveyor asked who assess residents' dental status related to nutrition. UM-J indicated that CNAs would do oral cares of residents and document if dentures are used. CNAs will also document the consumption of meals. The dietician will do the full assessment and follow up on everything else. Surveyor asked what is done if a resident does not have their dentures. UM-J indicated that the CNA would tell the nurse, the nurse can assess the resident then nurse would tell UM-J. From there, the dietician and therapy could get involved. Facility staff can downgrade their diet but not upgrade. So, the nurse can down grade to a soft diet for safety concerns. Surveyor informed UM-J and DON-B of the concern that R1 has been without R1's dentures since admission. This was not included in R1's nutritional assessment or care plan. In addition, Surveyor observed R1 unable to eat R1's fruit during lunch yesterday. DON-B stated that they would review this.WeightsR1's potential for nutritional risk care plan, dated 4/23/26, documents the following pertinent intervention: Weigh as ordered or per facility protocol.R1's MD order with a start date of 4/18/26 documents: Obtain weight upon admission, then weekly for four weeks, then monthly. Every day shift for baseline weight for 1 Day AND every day shift every [Wednesday] for weight for 4 Weeks .Surveyor reviewed R1's weights: 4/18/26 386 [pounds].5/13/26 388 [pounds].Surveyor noted that facility staff did not weigh R1 weekly as ordered.On 5/19/26 at 8:16 AM, Surveyor interviewed CNA-I. Surveyor asked how weights are completed and documented. CNA-I stated that they are done on admission and then monthly. CNA-I stated that the nurse will let CNAs know if they need to be done more than that. CNA-I stated that weights are documented in the vitals section of the Electronic Health Record.On 5/19/26 at 8:28 AM, Surveyor interviewed LPN-L. Surveyor asked what the facility policy is for residents' weights. LPN-L stated that the resident will have an MD order, and the nurse will have to let the CNA know that a weight is needed. LPN-L stated that it is a cumbersome process and will sometimes take nagging the CNA or asking multiple times to get a weight completed. LPN-L indicated that in the past (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-L had to get another CNA to get a weight completed because not all CNAs will do them as asked.On 5/19/26 at 10:02 AM, Surveyor interviewed Unit Manager (UM)-J and Director of Nursing (DON)-B. Surveyor asked what the facility weight policy is. UM-J stated that weights are completed on admission, weekly for 4 weeks and then monthly. Surveyor informed UM-J that R1's weight was documented on admission but was not completed weekly as ordered. DON-B indicated that they would review R1's weights. On 5/19/26 at 11:39 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the above concerns related to R1's nutrition assessment and weights. No further information was provided.