

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2025
NAME OF PROVIDER OR SUPPLIER Medical Suites at Oak Creek (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Honadel Boulevard Oak Creek, WI 53154	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interview, and review of call light data, the facility failed to ensure that five out of 46 residents (Resident (R) 156, R162, R65, R7, R109) call lights were answered timely. This failure increased the risk of residents not having their needs met. Findings include: Based on record review, observations, interview, and review of call light data, the facility failed to ensure that five out of 46 residents (Resident (R) 156, R162, R65, R7, R109) call lights were answered timely. This failure increased the risk of residents not having their needs met.</p> <p>Findings include:</p> <p>1. Review of R156's admission Record, located under the Profile tab of the electronic medical record, revealed she was admitted to the facility on [DATE] with diagnoses including femur fracture, asthma, muscle weakness, pain, and history of fall.</p> <p>Review of R156's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/25, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating cognitively intact.</p> <p>During an interview on 10/01/25 at 9:02 AM, R156 stated she felt the facility had a problem because it took too long to respond to her call light. She stated she had waited over an hour at times.</p> <p>During an observation in the back hall of the [NAME] unit on 10/03/25 beginning at 8:41 AM, R156's call light was illuminated in the hallway. Staff on the unit were beginning to pass out breakfast trays, and no staff were observed in the hall near R156's room. At 8:46 AM and again at 8:52 AM, the Occupational Therapist (OT) walked past the room and did not stop to respond to the call light. At 8:53 AM, Unit Manager (UM) 2 and the Scheduler (Sched)-S entered the hall near R156's room and proceeded to serve breakfast room to room starting at the opposite end of the hall as R156's room. R156's call light was not responded to until 9:03 AM, when UM2 brought in her breakfast tray.</p> <p>During an interview on 10/03/25 at 9:05 AM, UM2 stated she did not know R156's call light had been on for over 20 minutes, as the call bell sounds only at the nurses' station and not in hallways. UM2 confirmed there was no pager system to know when call lights were on. Review of R156's call light Report, dated 10/03/25 and provided on paper, revealed the call light had been activated at 8:20 AM and was not answered for 45 minutes</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of R162's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including urinary tract infection, chronic kidney disease, and diabetes.</p> <p>During an observation in the back hall of the [NAME] Unit on 10/03/25 beginning at 8:41 AM R162's call light was illuminating in the hallway Staff on the unit were beginning to pass out breakfast trays, and no staff were observed in the hall near R162's room. At 8:46 AM and again at 8:52 AM, the OT walked past the room and did not stop to respond to the call light. At 8:53 AM, UM2 and the Sched-S entered the hall near R162's room and proceeded to serve breakfast room to room starting at the opposite end of the hall as R162's room. R162's call light was not responded to until 9:03 AM, when Sched-S brought in her breakfast tray.</p> <p>During an interview on 10/03/25 at 9:15 AM, Sched- S stated she was only helping pass trays on the unit because one of the scheduled staff had not shown up for the shift. Sched-S was unaware the call light had been on for over 20 minutes.</p> <p>During an interview on 10/03/25 at 5:04 PM, CNA5 stated a staff member had called in that morning and they were working short one CNA until around 10:00 AM when the agency CNA arrived. CNA5 stated the S came to help pass meal trays because of this but she was not always available to help. CNA5 confirmed all staff were expected to respond to call lights.</p> <p>Review of R162's call light Report, dated 10/03/25 and provided on paper, revealed the call light had been activated at 8:20 AM and was not answered for 45 minutes. 3. Review of R65's admission Record, located in the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including sepsis, diabetes, prostate cancer, repeated falls, and muscle weakness. Review of R65's admission MDS, with an ARD of 09/27/25 and located under the MDS tab of the EMR, revealed he scored 12 out of 15 on the BIMS, indicating moderately impaired cognition.</p> <p>During an interview on 09/30/25 at 12:11 PM, R65 stated it took a long time for his call light to be answered, adding it could take at least an hour at times for any response. R65 described an incident of bowel incontinence, where he laid in the mess for over an hour before anyone responded to his call light.</p> <p>Review of R65's call light Reports, provided on paper, revealed several wait times over 20 minutes:09/06/25, 7:31 AM: 32-minute wait time;09/22/25, 1:09 PM: 41-minute wait time;09/23/25, 6:31 AM: 38-minute wait time;09/26/25, 10:29 AM: 32-minute wait time;09/29/25, 9:51 AM: 24-minute wait time.</p> <p>4. Review of R7's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include fracture of upper end of right humerus, unspecified fall, dependence on dialysis, generalized edema, and anxiety.</p> <p>Review of R7's significant change in status Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 08/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/30/25 at 8:35 AM, R7 stated there were not enough staff and she sometimes had to wait over an hour. She stated they would turn the call light off, and then she would have to push it again.</p> <p>Review of the Call Data Summary report, provided by the facility, dated from 09/02/25- 10/02/25, revealed the following for R7: -09/02/25, staff response was 21 minutes and 23 seconds. -09/08/25, staff response was 36 minutes and 22 seconds. -09/11/25 at 10:03 (AM), staff response was 45 minutes and 25 seconds. -09/11/25 at 13:24 (1.24 PM), staff response was 24 minutes and 54 seconds. -09/16/25, staff response was 22 minutes and 53 seconds. -09/17/25 at 8:44 (AM), staff response was 35 minutes and 43 seconds. -09/17/25 at 17:57 (5:54 PM), staff response was 31 minutes and 07 seconds. -09/18/25, staff response was 39 minutes and 42 seconds. -09/20/25, staff response was 30 minutes and 37 seconds. -09/23/25, staff response was 27 minutes and 58 seconds.</p> <p>5. Review of R109's Face Sheet located under the Profile tab of the EMR revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include end stage renal disease, type two diabetes, ascites, absence of right left knee, and sleep apnea.</p> <p>Review of R109's quarterly MDS located under the MDS tab of the EMR with an ARD of 08/27/25 revealed a BIMS score of 15 out of 15 which indicated R109 was cognitively intact.</p> <p>During an interview on 09/30/25 at 10:00 AM, R109 stated he had to wait a long time to get his call light answered.</p> <p>Review of the Call Data Summary report, provided by the facility, dated 09/02/25- 10/02/25, revealed the following for R109: -09/07/25, staff response was 27 minutes and 36 seconds. -09/11/25, staff response was 41 minutes and 30 seconds. -09/17/25, staff response was 26 minutes and 39 seconds. -10/01/25, staff response was 36 minutes and 55 seconds.</p> <p>6. During an observation on 10/03/25 at 4:30 PM, four call lights were observed activated on the back hallway of the [NAME] unit. There were no staff found in the back hallway, and a tour through the unit located three staff members in a clinical office talking and laughing. No additional staff were observed on the floor. At 4:40 PM,) CNA 7 was observed returning to the unit from her break. CNA7 immediately began answering the four call lights that were illuminated. During an interview on 09/30/25 at 11:14 AM, Licensed Practical Nurse (LPN) 4 stated they usually only had one Certified Nurse Aide (CNA) and that was not enough. She stated the expectation was for the nurse to also be an aid. She stated they had a lot of Hoyer's and sit-to-stands. She stated it took longer to get med pass completed because of the interruptions and they had to take the residents to and from dialysis. She stated the CNA's had to do the residents' showers as well.</p> <p>During an interview on 10/01/25 at 8:46 AM, CNA2 stated most of the time, they only had one CNA. She stated when she was the only one, the residents had to wait a long time. She stated wait times were long, when she had to go to another unit to find someone to help. She stated they needed someone to help get through the morning rush.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/01/25 at 12:51 PM, the Director of Nursing (DON) stated they had a lot of staffing changes for management. She stated she did not think there was a problem with staffing, and they were able to find replacements for call-offs. She stated the ratio they tried for was 10:1 CNA, and 10:1 Nursing. She stated [NAME] (400-hall) had no more than 15 residents so they would have one nurse, one CNA, and they tried to get half shift to help with residents. She stated she stressed teamwork and that the staff should obtain assistance from other halls. She stated they had a floating supervisor, but that person got called to the floor sometimes.</p> <p>During an interview on 10/03/25 at 4:50 PM, CNA7 stated she had been on break, and she had reported to the nurse on the floor that she would be gone. She stated the other staff on the unit, including the nurse, were to answer call lights in her assigned rooms while she was on break., CNA7 stated it was the job of all staff to respond to a call light when they saw it CNA7 stated the unit was staffed by census, even though the residents in the unit had high medical acuity and a lot of complex needs. CNA7 the census had increased and now three CNAs were working on the unit.</p> <p>During an additional interview on 10/03/25 at 5:38 PM, the Director of Nursing (DON) stated she expected all staff to answer call lights and not walk past them without checking on what the resident needed. The DON stated that while there was no certain time frame she expected a response, she stated when 10 to 15 minutes went by, that it was getting long, and there should not be any response times longer than 20 minutes.</p> <p>Review of the Resident Council notes, provided by the facility and dated 08/15/25, revealed Residents request that the nursing staff help more and do more rounds.</p>		

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

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure code status was accurately reflected in the electronic medical record (EMR) for one of 30 residents (Resident (R) 83) reviewed in the Initial Pool out of a census of 116. This failure had the potential for R83 to receive cardiopulmonary resuscitation (CPR) when the wishes of the resident were to die a natural death, which could contribute to physical injury or emotional anguish.</p> <p>Findings include:</p> <p>Review of R83's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] following hospitalization for right tibia and patellar fractures and had diagnoses including depression, anxiety, and bipolar disorder.</p> <p>Review of R83's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab of the EMR, revealed she scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition.</p> <p>Review of R83's Profile tab of the EMR revealed she was to receive CPR (cardiopulmonary resuscitation, or full code).</p> <p>Review of R83's Resident Code Status form, dated [DATE] and located under the Miscellaneous tab of the EMR, revealed R83 signed the form electing a DNR (do not resuscitate, or no CPR) status.</p> <p>Review of R83's EMR under the Orders tab revealed an order, dated [DATE] and entered by Unit Manager (UM) 3, to provide CPR.</p> <p>Review of R83's Social Services Evaluation note, dated [DATE] and located under the Progress Notes tab of the EMR, revealed, Resident is a DNR, responsible for self and A&Ox3 [alert and oriented times three].</p> <p>During an interview on [DATE] at 12:50 PM, UM 2 stated the protocol was to follow the physician order or the Profile in the EMR for code status and stated R83 was listed as Full Code in the EMR, meaning she would receive CPR. UM2 confirmed the Resident Code Status form reflected the resident's choice for DNR and the Profile and physician's order in the EMR were not correct.</p> <p>During an interview on [DATE] at 12:56 PM, Licensed Practical Nurse (LPN) 1 verified in the EMR R83 was to receive CPR if her heart stopped.</p> <p>During an interview on [DATE] at 1:45 PM, R83 stated she signed the DNR form at admission and did not want CPR provided in the event her heart stopped. R83 stated she had a bracelet on her arm that listed DNR status.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:46 PM, LPN2 stated she spoke with R83 about code status and completed the Code Status Form with R83 on admission. She stated R83 expressed a desire for no CPR. LPN2 stated she did not recall if she was the one who put in the orders for code status and was not aware there was an order for CPR in the EMR.</p> <p>During an interview on [DATE] at 9:02 AM, UM3 stated she did not recall entering R83's orders in the EMR and did not know the order did not match the resident's preference.</p> <p>During an interview on [DATE] at 11:50 AM, the Director of Nursing (DON) stated she expected the staff entering admission orders in the EMR to refer to the completed Code Status Form for accurate information and double-checking orders for accuracy. She stated the process was for the admitting nurse to enter orders and for a second nurse to verify the information entered in the EMR; however, this process needed to be tightened up.</p> <p>Review of the policy titled, Communication of Code Status, dated [DATE], revealed, When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to:</p> <ul style="list-style-type: none"> a. Full Code b. Do Not Resuscitate c. Do Not Intubate d. Do Not Hospitalize. 		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and document review, the facility failed to notify the ombudsman of discharges and failed to provide a transfer notice and bed hold policy to the resident and/or Resident Representative (RP) for one of three residents (Resident (R)12) reviewed for discharges out of a total of 30 sampled residents. This failure had the potential for the residents and RP to be misinformed of the transfer out of the facility. Findings include:Based on record review, interview, and document review, the facility failed to notify the ombudsman of discharges and failed to provide a transfer notice and bed hold policy to the resident and/or Resident Representative (RP) for one of three residents (Resident (R)12) reviewed for discharges out of a total of 30 sampled residents. This failure had the potential for the residents and RP to be misinformed of the transfer out of the facility.</p> <p>Findings include:</p> <p>Review of R12's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R12 was originally admitted to the facility on [DATE] with the diagnosis of thrombocytopenia (a condition where the number of platelets in the blood is abnormally low) and anemia.</p> <p>Review of R12's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 05/27/25 indicated R12 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R12 was cognitively intact.</p> <p>Review of R12's SNF/NF [Skilled Nursing Facility/Nursing Facility] to Hospital Transfer Form located under the Evaluation tab in the EMR and dated 07/25/25 indicated R12 was being transferred to the hospital for GI [gastrointestinal] bleeding.</p> <p>Continued review of R12's EMR indicated the Bed Hold/Transfer Notice located under the Evaluation tab revealed a section which stated, This notice is presented to you because of the following: Transfer to _____ hospital due to _____. This notice fulfills requirement to remind you of this facility's bed hold policy. Please read carefully and indicate whether or not you wish to reserve your room. The form was not filled out regarding why, or to where, R12 was transferred. R12 did not sign the form. The only signature on the form was of the nurse who filled out the form.</p> <p>During an interview on 10/02/25 at 12:50 PM, Social Worker (SW)1 stated she was only able to find ombudsman notifications for the month of September 2025.</p> <p>During an interview on 10/02/25 at 1:50 PM, the Director of Nursing (DON) stated, We do not have any notifications for the months of July and August for the Ombudsman notifications. We only had one social worker during that time, and the Director of Social Services was one position that was vacant. She [Director of Social Services] was responsible for doing this on a monthly basis.</p> <p>During an interview on 10/03/25 at 8:45 AM, Unit Manager (UM)1 reviewed the Bed Hold/Transfer Notice dated 07/25/25. UM1 stated, The nurse is responsible to fill out the Bed Hold/Transfer Notice completely and have the resident sign it.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/25 at 9:18 AM, the Director of Nursing (DON) stated, We have a bed hold form that is gone over with either the resident and or the RP verbally. If it is the resident, then when it is explained to the resident, the nurses will get this signed and make a copy. The resident gets a copy and then we upload a copy to PCC [Point Click Care- the EMR].</p> <p>Review of the facility's policy Bed Hold Notice Upon Transfer dated 10/29/24 indicated, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's medical record.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to ensure the Care Plan for one of two residents reviewed for behaviors (Resident (R) 2) out of a total sample of 30 reflected their behavioral health needs. This failure created potential for lack of behavioral intervention for R2. Findings include: Based on interviews, record review, and facility policy review, the facility failed to ensure the Care Plan for one of two residents reviewed for behaviors (Resident (R) 2) out of a total sample of 30 reflected their behavioral health needs. This failure created potential for lack of behavioral intervention for R2.</p> <p>Findings include:</p> <p>Review of R2's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including fibromyalgia, morbid obesity, and depression. Review of R2's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/26/25 and located under the Profile tab of the EMR, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. She did not exhibit any mood or behavioral symptoms.</p> <p>During an interview on 09/30/25 at 3:13 PM, R2 stated she had requested Certified Nurse Aide (CNA) 3 no longer work with her and added, I don't like her appearance. R2 stated the staff had accused her of threatening to have her family come into the facility to beat up CNA3. Additionally, R2 described a situation where she and her family were upset with facility staff and caused a commotion in the lobby and had words with the Business Office Manager (BOM) as they were leaving for an outing. During an interview on 10/03/25 at 10:16 AM, the BOM stated she had provided R2 reminders that she could not stay out of the facility overnight due to insurance requirements, and she had reiterated the statement again to R2 and her family members. The BOM stated R2 and her family members were screaming in the lobby and getting loud and angry, stating they did not want to speak with the BOM any longer. The BOM stated R2 was cursing and calling her names.</p> <p>During a concurrent interview on 10/03/25 at 1:06 PM with the Administrator and Director of Nursing (DON), the DON stated she heard from staff that R2 threatened to have her family members beat up CNA3. She stated after that, the resident and her family became aggressive with staff and acted inappropriately before leaving the facility for a visit. The DON stated there were no interventions implemented, such as care in pairs, that she was aware of. The DON stated there should have been a Care Plan addressing R2's behavioral symptoms; however, she was unable to locate one. The DON stated she would immediately create a Care Plan addressing behaviors. The Administrator stated the only approaches that had been implemented to address R2's behaviors were anticipating her needs and spending time speaking with her and listening. During an interview on 10/03/25 at 3:18 PM, Unit Manager (UM) 2 stated R2 exhibited behaviors including noncompliance with ordered diet, making accusatory statements, and threatening the staff. UM2 stated she would expect a Care Plan addressing R2's behaviors with specific interventions to manage the behaviors. UM2 stated she was unsure of any interventions put in place, but she did ask another staff member to go with her when she had to have conversations with R2 at times because of her behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/25 at 3:51 PM, CNA3 stated there was an instance where R2 began complaining about her and said she did not want to work with her. CNA3 asked a different CNA to provide care to the resident that day and she has not worked with R2 since then. CNA3 stated R2 was overheard threatening to call her family members to come in and beat up CNA3. CNA3 stated she was afraid that day because R2's family members had shown up to the facility and R2 and her family were yelling and cussing in the lobby. CNA3 also stated R2 voiced several unfounded accusations, such as not receiving a skin check at admission or gaining 70 pounds when only a five-pound weight gain was present. During an interview on 10/03/25 at 4:22 PM, the Social Worker (SW) stated she had heard reports of R2 calling the staff names, making accusations, and threatening the staff; however, she had not witnessed the behavior firsthand. The SW stated she was in the process of setting up psychiatric services for R2 and would expect the Care Plan to reflect her behaviors and any pertinent approaches. The SW stated the interdisciplinary team was responsible for creation of the comprehensive Care Plan and any of the staff could have input information regarding R2's behaviors.</p> <p>Review of the policy titled, Care Planning-Resident Participation, dated 07/01/25, revealed, The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>Review of the policy titled, Behavioral Health Services, dated 08/01/25, revealed, The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p>		

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

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

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

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to address a significant weight loss of 19% in one month for one of five residents reviewed for nutrition (Resident (R) 3) out of a total sample of 30 residents. This failure had the potential to contribute to further weight loss, malnutrition, muscle wasting, weakness, and death. Findings include: Review of R3's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she admitted to the facility on [DATE] and re-admitted on [DATE]. She had diagnoses including Parkinson's disease, dementia, diabetes, dysphagia, stage IV sacral pressure ulcer, additional unstageable pressure ulcer of back/buttock/hip, additional stage IV pressure ulcer, contractures, and history of stroke. Per R3's EMR under the Census tab R3 was hospitalized from [DATE] through 08/04/25. Review of R3's significant change of condition Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/08/25 located under the MDS tab of the EMR revealed a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS revealed R3 did not exhibit behavioral symptoms and had no chewing or swallowing problems. R3 had an unplanned weight loss of 5% or more in the last month and received a mechanically altered, therapeutic diet.</p> <p>Review of R3's EMR under the Vitals tab revealed R3's weights were: 07/12/25: 152.2 pounds (lbs) 07/18/25: 157.8 lbs 08/08/25: 155.8 lbs 08/25/25: 154.1 lbs 09/05/25: 130.4 lbs 09/13/25: 128.4 lbs 09/16/25: 127.7 lbs 09/17/25: 127.0 lbs 09/18/25: 126.9 lbs 09/19/25: 126.9 lbs 09/20/25: 126.9 lbs 09/20/25: 126.9 lbs 09/22/25: 125.8 lbs 09/24/25: 124 lbs On 08/25/25, R3 weighed 154.1 lbs. On 09/24/25, R3 weighed 124 lbs, which is a 19.53% loss in one month.</p> <p>Review of R3's Care Plan dated 09/25/25 and located under the Care Plan tab of the EMR revealed the following for 06/30/25: [R3] is at nutritional risk d/t [due to] wound infection, dx [diagnosis] of dysphagia, texture modified diet, elevated BMI [body mass index], dx of dementia, need for assistance with feeding/drinking [and increased nutritional needs due to wound healing (stage III coccyx, stage IV right palm, stage IV right sacrum, deep tissue injury (DTI) to left heel and left metatarsal)] . wt [weight] flux [fluctuation] anticipated due to fluid shifts, sig [significant] wt loss x30d [days]. The goal was for The resident will maintain adequate nutritional status as evidenced by maintaining weight within +/-10 lb CBW [current body weight] without significant weight changes, no s/sx [signs or symptoms] of malnutrition, tolerate least restrictive diet, and consume at least 50% of at least 3 meals daily and ordered supplements, maintain adequate hydration w/o [without] s/sx of dehydration or fluid overload, shows signs of skin improvement, maintain labs WNL [within normal limits] for age/condition through review date. The approaches included: Administer medications as ordered. Monitor/Document for side effects and effectiveness . 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 . Monitor/record/report to MD [physician] PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months . Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated . Provide and serve diet as ordered. Monitor intake . Provide and serve supplements as ordered . Provide total assistance with feeding/drinking . RD [Registered Dietician] to evaluate and make diet change recommendations PRN . [and] Weigh as ordered or per facility protocol. Monitor for changes.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/04/25, the Care Plan focus was revised to include, increased nutritional needs to due to wound healing (stage III coccyx, stage IV right palm, stage IV right sacrum, deep tissue injury (DTI) to left heel and left metatarsal) . wt flux anticipated due to fluid shifts. However, no new or revised approaches were added to the Care Plan.</p> <p>On 09/19/25, the Care Plan focus was revised to include, Sig [significant] wt loss x 30d [days]. However, no new or revised approaches were added to the Care Plan. Review of R3's EMR under the Orders tab revealed a physician's order dated 08/12/25for furosemide (a diuretic medication), 20 milligrams (mg) once a day for chronic kidney disease and edema. Additionally, there was a physician's order dated 08/06/25for 30 milliliters (ml) of liquid protein twice daily for supplement and a physician's order dated 08/06/25for eight ounces (oz) of Boost supplement twice daily (BID). Review of R3's Nutritional Evaluation dated 09/04/25 located under the Evaluations tab of the EMR revealed her most recent weight was 154.1 lbs on 08/25/25 and her body mass index was normal at 22.8. Her ideal body weight was 144 to 176 lbs. The evaluation documented[R3] is here for rehab. COC [change of condition] r/t [related to] newly acquired wound. Receives regular diet w/ [with] mech [mechanical] soft texture. Appetite is good. PO [oral] intake adequate between 75-100%. Requires assistance with eating/drinking due to hand contractures . Dx dysphagia - on texture modified which is approp [appropriate]. Skin reviewed: St [stage] 3 - coccyx; St 4 &ndash; R [right] palm under 5th digit, R sacrum; unstageable - R 2nd finger knuckle. Palm/knuckle wounds are new d/t hand contractures . Wt stable without any recent significant changes. Weight maintenance is most appropriate in presence of advanced age. Most recent weight from August, request for current weight for month of September made. Has increased needs r/t wound healing. Receives Boost BID, liquid protein BID and MVI [multivitamin] all approp for wound healing. R3 was at risk for malnutrition.</p> <p>Review of R3's Physician/Practitioner Progress Notes dated 09/19/25 located under the Progress Notes tab of the EMR revealed Denies change in appetite. The physician did not implement any interventions to address weight loss at this time.</p> <p>Review of R3's 09/19/25 Nutrition/Dietary Note dated 09/19/25 located under the Progress Notes tab of the EMR revealed CBW :126.9 lb (9/19). BMI [body mass index]18.7 &ndash; normal. Wt hx [history]: 130.4lb (9/5), 154.1lb (8/25), 152.2lb (7/12). Most recent weight shows recent sig [significant] wt loss x30d (-27.2lb, -17.7%) and (-25.3lb, -16.6%). She has been reweighed multiple times to confirm accuracy of weight changes, and her weight remains lower than weights at admission. Some may be related to diuretic use/fluid shifts and/or accuracies with admission weights. She was also briefly on a wound vac that may have pulled off some fluid since admission. However, still concern that weight loss may be related to PO intake. Continues a regular, mech [mechanical] soft diet w/thin liquids. She requires total assistance with feeding/drinking. Visited Thursday during breakfast while she was being fed. Was doing well at meals and reported not having any changes in her appetite or any changes with her chewing/swallowing. Meal intake is adequate at 75-100% majority of meals. Tolerates diet. Accepts fluids. Receives Boost BID and liquid protein BID for nutrition support/wound healing. Accepts supplements. Skin reviewed: St 3 &ndash; coccyx & R 2nd finger knuckle; St 4 &ndash; R palm (under 5th digit) & R sacrum and new DTI to L-heel. Noted wounds are suspected to be unavoidable due to condition. Supplements and MVI approp to support wound healing. No new recommendations at this time in presence of adequate PO intake and supplements. Continue POC (plan of care) and monitor. No new interventions were put into place on 09/19/25 when the RD was notified of the weight loss.</p> <p>Review of R3's September 2025 POC [Point of Care] Response History located under the Tasks tab of the EMR revealed R3 ate 75% to 100% at all meals but one.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's Medical Practitioner Note, dated 09/04/25 and located under the Progress Notes tab of the EMR, revealed, She is underweight. She is ill-appearing and toxic-appearing. BUN . (blood urea nitrogen - a medical test that measures the amount of urea nitrogen found in blood produced as a waste product of the digestion of protein &ndash; value) Date Value 09/01/2025 31 (H) [high]. The physician did not implement any new interventions at this time to address her underweight status or high BUN level. During an interview on 10/02/25 at 2:49 PM, the Registered Dietician (RD) stated R3 lost a significant amount of weight since her admission and had nutritional concerns because of several open wounds, a need for assistance with eating, and dysphagia. The RD stated it was suspicious that there was such a significant loss in such a short time; however, she could not assume the weights were inaccurate as several re-weights and re-checks had been done to confirm the numbers. The RD stated R3 had received Boost twice daily and liquid protein twice daily since her admission for wound healing but there were no additional measures put into place to address her recent weight loss. The RD stated she did not implement any new interventions to address R3's weight loss because she didn't know what else to offer, and we don't have a lot of options. The RD stated the facility did not offer a fortified foods program but R3 could benefit from additional interventions, such as providing more snacks or larger portions. The RD stated that if a resident were at nutritional risk and was experiencing significant weight loss, she would offer additional interventions, such as large portions, supplements, or snacks, to address the weight loss. The RD confirmed no other interventions as listed were added. During an interview on 10/03/25 at 12:00 PM, the Director of Nursing (DON) stated she was unaware of R3's significant weight loss. She stated she would have expected the RD to implement new interventions when the weight loss was discovered to prevent further weight loss and encourage wound healing. The DON stated the facility held weekly meetings to discuss residents with wounds, and weights should be discussed during these meetings. The DON stated if the weight loss had been discussed in the weekly meeting, it would be on her radar to ensure follow up by the RD.</p> <p>During observations on 09/30/25 at 12:34 PM and 10/02/25 at 9:13 AM, R3 was observed receiving one-to-assistance with eating, and she consumed 100% of both meals.</p> <p>Review of the policy titled Weight Monitoring dated 10/30/24 revealed Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutrition status, such as usual body weight or desirable body weight range and electrolyte balance . A significant change in weight is defined as: 5% change in weight in 1 month (30 days) . The physician should be informed of a significant change in weight and may order nutritional interventions . The Registered Dietician or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of policy and procedures, the facility failed to follow infection control guidelines for the storage of a nebulizer mask for one (Resident (R)132) of three residents reviewed for respiratory care out of 30 sampled residents. This failure had the potential to increase infections in vulnerable residents receiving respiratory care in the nursing facility. Findings include: Review of R132's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R132 was readmitted to the facility on [DATE] with the diagnoses to include chronic obstructive pulmonary disease</p> <p>Review of R132's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 08/09/25 indicated R132 was coded for a Brief interview for Mental Status (BIMS) score of 11 out of 15 which indicated R132 was moderately cognitively impaired.</p> <p>Review of R132's Physician Orders located under the Orders tab in the EMR indicated an order dated 09/30/25 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligram)/3 ml (milliliter) three ml inhale orally every six hours as needed for shortness of breath and/or cough. This medication was to be inhaled by R132 through a nebulizer mask.</p> <p>An observation on 10/02/25 at 9:52 AM and at 12:22 PM, R132's nebulizer mask was attached to the nebulizer machine and was lying on top of the bedside table without being in a bag, uncovered.</p> <p>At 12:25 PM, Registered Nurse (RN)2 went into R132's room and confirmed the nebulizer mask was lying on top of the bedside table. RN2 stated, It needs to be in a plastic bag. Let me go and get one and fix this right now.</p> <p>During an interview on 10/02/25 at 12:30 PM, Unit Manager (UM)1 stated, The mask should have been stored in a Ziploc bag or something like that when not in use.</p> <p>During an interview on 10/02/25 at 1:20 PM, the Infection Preventionist (IP) nurse stated, The nebulizer mask should be stored in a plastic bag.</p> <p>Review of the facility's policy/guidelines Nebulizer Therapy dated 04/09/25 indicated, .store the nebulizer mask and the mouthpiece in a zip loc bag.</p>		

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

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

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

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

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

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

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure ongoing assessment and monitoring for complications before and after dialysis treatments were completed to ensure communication with the dialysis facility for one (Resident (R) 111) of one resident reviewed for dialysis out of a total sample of 30 residents. This failure had the potential to lead to uncommunicated and unassessed changes or complications for R111 and other residents receiving dialysis. Findings include: Review of R111's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of end stage renal disease and dependence on renal dialysis. Review of R111's admission Minimum Data Set (MDS) with an Assessment Reference Date of 09/25/25 revealed she scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. The MDS further indicated she received hemodialysis.</p> <p>Review of R111's EMR under the Orders tab revealed a physician's order dated 09/23/25 for dialysis every Tuesday, Thursday, and Saturday and a physician's order dated 09/23/25 for Dialysis - Communication Form. Nurse to fill form out correctly, place in RED folder and send with resident to dialysis.</p> <p>Review of R111's Care Plan dated 09/29/25 and located under the Care Plan tab of the EMR revealed The resident needs hemodialysis r/t [related to] renal failure. The approaches included Monitor/document/report PRN [as needed] for s/sx [signs and symptoms] of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds [and] Monitor/document/report PRN for s/sx of the following: bleeding, hemorrhage, bacteremia, septic shock.</p> <p>Review of R111's EMR under the Miscellaneous tab revealed there were no records of the Dialysis Communication Form since her admission. During an interview on 10/03/25 at 11:10 AM, the Director of Nursing (DON) stated she was able to locate one Dialysis Communication Form that had been completed for R111 on 09/24/25. The DON stated she was unsure why she was unable to locate any additional completed forms. The DON verified there was only one Dialysis Communication Form for R111.</p> <p>Review of R111's dialysis Communication Report dated 09/24/25 provided on paper revealed only the resident's pre-dialysis weight had been filled out. The areas to document code status, vital signs, blood glucose, whether food was consumed prior to treatment, resident cognitive orientation, pain, changes of condition, and additional precautions were left blank. The dialysis staff fully completed the post-treatment section.</p> <p>During an interview on 10/03/25 at 12:53 PM, the dialysis registered nurse (DRN) stated the facility nursing staff were responsible for completing the pre-dialysis portion of the Dialysis Communication Form for every dialysis visit; however, she did not always receive them. The DRN stated at times the dialysis staff would complete the pre-dialysis section of the form if it was not received from facility staff. The DRN stated she was able to locate one completed Dialysis Communication Form for R111, dated 10/02/25. The DRN stated the dialysis staff were to upload all completed forms into the system as well as the Miscellaneous tab of the EMR, so she was unsure why only one form was available for R111. The DRN stated R111 received dialysis on 09/24/25, 09/25/25, 09/27/25, 09/30/25, and 10/02/25.</p> <p>Review of R111's dialysis Communication Report dated 10/02/25 provided on paper revealed it had been completed except for the area to record the pre-dialysis weight.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/25 at 12:57 PM, Licensed Practical Nurse (LPN)7 stated her unit was high traffic with many admissions or discharges daily, she was not always able to complete the dialysis Communication Report including monitoring the resident's vital signs.</p> <p>Review of the policy titled, Hemodialysis, dated 12/02/24, revealed, The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as dialysis communication form or other form, that will include, but not limit itself to: a. Timely medication administration (initiated, held, or discontinued) by the nursing home and/or dialysis facility.b. Physician/treatment orders, laboratory values, and vital signs;c. Advance directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners;d. Nutrition/fluid management including documentation of weights, resident compliance with food/fluid restrictions, or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered;e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments;f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site;g. Changes and/or declines in condition unrelated to dialysis.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure medication administration was timely for one of one resident (Resident (R) 109) reviewed for late medications out of 30 sampled residents. This failure had the potential to interfere with the medication effectiveness. Findings include: Review of R109's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include end stage renal disease, type two diabetes, ascites, absence of right left knee, and sleep apnea. Review of R109's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 08/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R109 was cognitively intact. During an interview on 09/30/25 at 10:04 AM, R109 stated he did not get his medications on time. He stated medication that was due at 7:00 AM, he may not get it until 9:40 AM. He stated medications scheduled for 7:00 PM were maybe 45 minutes late. Review of the Medication Admin Audit Report, provided by the facility, revealed: On 09/19/25: scheduled for 20:00 (8:00 PM) and documented as administered at 09/19/25 at 23:45 (11:45 PM). Melatonin oral capsule 3 mg [milligram]. Give 2 capsules by mouth at bedtime for sleeplessness. The administration was two hours 45 minutes late. On 09/19/25: scheduled for 20:00 (8:00 PM) and documented as administered at 09/19/25 at 23:45 (11:45 PM). Pantoprazole sodium tablet delayed release 40 mg. Give 1 tablet by mouth two times a day for heartburn. The administration was two hours 45 minutes late. On 09/19/25: scheduled for 20:00 (8:00 PM) and documented as administered at 09/19/25 at 23:46 (11:46 PM). Rifaximin oral tablet 550 mg. Give one tablet by mouth every 12 hours for hepatic encephalopathy. The administration was two hours 46 minutes late. On 09/29/25: scheduled for 9:00 (AM) and documented as administered at 09/29/25 at 14:48 (2:48 PM). Sertraline HCL tablet 50 mg. Give 1 tablet by mouth one time a day for depression. The administration was four hours and 48 minutes late. On 09/29/25: scheduled for 8:00 (AM) and documented as administered at 09/29/25 at 14:48 (2:48 PM). Pantoprazole sodium tablet delayed release 40 mg. Give 1 tablet by mouth two times a day for heartburn. The administration was five hours and 48 minutes late. On 09/29/25, scheduled for 8:00 (AM) and documented as administered on 09/29/25 at 14:48 (2:48 PM). Atorvastatin calcium oral tablet 20 mg. Give 1 mg by mouth one time a day for monitoring. The administration was five hours and 48 minutes late. On 09/29/25: scheduled for 8:00 (AM) and documented as administered at 09/29/25 at 14:48 (2:48 PM). Rifaximin oral tablet 550 mg. Give one tablet by mouth every 12 hours for hepatic encephalopathy. The administration was five hours and 48 minutes late. During an interview on 09/30/25 at 11:14 AM, Licensed Practical Nurse (LPN) 4 stated that the medication pass was late at times related to staffing. During an interview on 10/02/25 at 6:04 PM, the Director of Nursing (DON) stated the expectation was for medications to be passed from one hour before to one hour after the designated time. She stated she noticed the nurses documenting on the residents at the end of the day instead of during medication administration but was unable to determine if this was what occurred for R109. She stated nurses needed to document immediately after administration. She stated she trained the staff on September 3, 4, 9, and 10th, 2025 regarding this issue. She stated she did not have a chance to pull audits for medication administration. Review of the facility's policy titled, Medication Administration, revised 04/09/25, revealed 10. Ensure that the six rights of medication administration are followed. 2. Right time. 12. Compare medication source. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.</p>		

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

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

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

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

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

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

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observations and interviews, the facility failed to ensure the exterior trash area was free from debris and the doors were closed on two of two trash bins with the ability to affect all 116 census residents. This failure had the potential to contribute to pest infestation. Findings include: During an observation on 10/02/25 at 10:37 AM, with the Food Service Director (FSD) two trash bins were noted outside near the kitchen. One of the trash bins was designated for recycling only. Two of two lids were in an open position and there was trash debris on the ground surrounding the bin. The second trash bin was designated for trash only. Two of two lids were in the open position and there was trash debris (gloves, a mask, and an empty plastic container of V-8) on the ground surrounding the bin. The second trash bin was overflowing with trash bags. The FSD acknowledged that the lids should have been shut, and the debris should have been cleaned. He stated the dietary staff took the trash out after each meal.</p> <p>During an interview on 10/02/25 at 3:00 PM, the Registered Dietitian (RD) stated she did not go out to check the trash area.</p> <p>During an interview on 10/02/25 at 4:01 PM, the Administrator stated they did not have a policy for the trash.</p>

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

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Base on QAPI record reviews, interviews, and facility policy review, the facility failed to develop and implement a Quality Assurance and Performance Improvement (QAPI) process to address identified deficient practices resulting in continued noncompliance. Lack of developing and implementing improvement plans for identified problems through the QAPI process could lead to prolonged periods of non-compliance affecting residents, staff, and families accordingly thus affecting all 116 residents. Findings include:Review of the facility's 07/15/24 Statement of Deficiencies, CMS-2567 found in the facility's Survey Results binder near the front entrance, revealed the facility was cited for:F804: Food PalatabilityF814: Proper Garbage/Refuse DisposalF880: Infection Prevention and Control</p> <p>During the survey on 09/30/25 through 10/03/25, the facility was again cited for all deficiencies listed above related to similar deficient practices. Cross-reference:F804: The facility failed to serve food at palatable temperatures.F814: The facility failed to dispose of garbage in a sanitary manner.F880: The facility failed to follow infection control practices.</p> <p>During an interview on 10/03/25 at 5:23 PM, the Administrator stated the survey results were a major source of information to determine necessary quality improvement activities. The Administrator indicated QAPI had not implemented and/or fully developed performance plans for tags F-804-Food Palatability, F-814-Garbage and F880-Infection control, all of which were cited on the previous survey of 07/15/24 and cited for the annual survey on 10/03/25. He stated food palatability or F804 had been identified; however systemic changes had not yet been implemented because there were no metrics or tools developed to monitor and evaluate progress.</p> <p>In regard to garbage disposal or F814, the Administrator stated on 10/03/25 at 5:23 PM this issue had been followed briefly in QAPI, as they noticed the garbage disposal company was not coming consistently to empty the dumpsters. The Administrator stated he was looking at getting a daily pick up and had seen the lids left open and/or gloves and trash on the ground next to the dumpsters; however, he had not revisited this issue in QAPI or implemented any new corrective measures.</p> <p>In regard to infection control or F880, the Administrator stated on 10/03/25 at 5:23 PM he was aware the infection control program was not where it needs to be. He stated the facility identified a need for more education regarding enhanced barrier precautions in April but had not implemented any additional infection control performance improvement projects addressing other pieces of the program, such as hand hygiene, transmission-based precautions, or antibiotic stewardship.</p> <p>Review of the policy titled, Quality Assurance and Performance Improvement (QAPI), dated 02/05/25, revealed, It is the guideline of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides . The facility draws from multiple sources, including input from all staff, residents, families, and others as appropriate. Data sources may include, but are not limited to: . Survey outcomes . All identified problems will be addressed and prioritized . The facility takes actions aimed at performance improvement as documented in QAA Committee meeting minutes and action plans. Performance/success of the actions will be monitored and documented in subsequent QAA Committee or sub-committee meetings.</p>		

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

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

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, document review, policy review, and review of McGeer's criteria, the facility failed to have an Antibiotic Stewardship Program that followed current standards of practice for prescribing an antibiotic for three of three residents (Resident (R)5, R62, and R96) reviewed for antibiotic stewardship out of total sample of 30 residents. This failure had the potential for residents to be prescribed unnecessary antibiotics. Findings include: 1. Review of R5's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R5 was originally admitted to the facility on [DATE] with the diagnosis of malignant neoplasm of the spinal cord.</p> <p>Review of R5's Provider Progress Notes located under the Progress Notes tab in the EMR dated 08/30/24 indicated, .The patient presents today with complaints of dysuria, urinary frequency, and an odor to her urine. She [R5] reports that these symptoms began approximately on Monday.</p> <p>Review of the Physician's Orders located under the Orders tab in the EMR indicated an order dated 09/01/24 for Macrobid (an antibiotic) 100 mg (milligrams) one capsule by mouth two times a day for infection for seven days.</p> <p>During an interview on 10/03/25 at 6:45 PM, the Infection Preventionist (IP) stated, I could not find any lab results for the urinalysis and C&S [culture and sensitivity] for this resident. I also could not find any further nursing documentation of the symptoms the resident was having. The IP confirmed this did not meet McGeer's criteria due to R5 not having symptoms indicated by the criteria for a urinary tract infection (UTI) at the time. With no lab results, the IP was unable to verify the correct antibiotic was ordered.</p> <p>2. Review of R62's undated Face Sheet located under the Profile tab in the EMR indicated R62 was originally admitted to the facility on [DATE] with the diagnosis of malignant neoplasm of unspecified kidney and chronic obstructive pulmonary disease.</p> <p>Review of the Provider's Progress Notes located under the Progress Note tab in the EMR indicated a note dated 03/06/25 which stated, .Does report she [R62] has symptoms of UTI [urinary tract infection] .</p> <p>Review of R62's Urinalysis results dated 03/06/25 and provided by the facility indicated a large amount of leukocytes esterase, blood small amount, and bacteria was too many to count.</p> <p>Review of R62's Physician Orders located under the Orders tab in the EMR indicated an order dated 03/07/25 for Ciprofloxacin (an antibiotic) 250 mg give one tablet by mouth every 12 hours for infection for four days. The physician ordered Ciprofloxacin 250 mg give one tablet two times a day to be continued for four additional days on 03/10/25.</p> <p>Review of the Urine Culture and Sensitivity results dated 03/13/25 and provided by the facility indicated two organisms present, which were Escherichia coli (Organism 1) 50,000 &ndash; 100,000 colonies/milliliter and Proteus mirabilis (Organism 2) 50,000 &ndash; 100,000 colonies/milliliter. Organism 1 was susceptible to Ciprofloxacin, but Organism 2 was not.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/03/25 at 6:50 PM, the IP stated, There was no documentation in the nurses' notes to reflect what symptoms the resident was having or why a urinalysis was ordered. The IP confirmed this did not meet McGeer's criteria due to there being no documentation of R62's symptoms prior to obtaining a urinalysis.</p> <p>3. Review of R96's undated Face Sheet located under the Profile tab in the EMR indicated R96 was admitted to the facility on [DATE] with the diagnosis of type two diabetes mellitus.</p> <p>Review of R96's emergency room papers brought back to the facility on [DATE], which were provided by the facility, indicated R96 had a urine infection.</p> <p>Review of Physician Orders located under the Orders tab in the EMR revealed R96 returned from the emergency room on [DATE] with an order for Keflex (an antibiotic) 500 mg three times a day for seven days.</p> <p>During an interview on 10/03/25 at 6:55 PM, the IP stated that she was unable to find a laboratory test to support the need for antibiotics because the resident went to the emergency room. The IP confirmed this did not meet McGeer's criteria since there was no documentation of symptoms the resident was having, and there were no lab results to justify the use of antibiotics.</p> <p>Review of the facility's monthly Line Listing for Infections which was provided by the facility and was dated August 2024 through September 2025 revealed: no documentation whether infections met or did not meet McGeer's Criteria, no consistent documentation of the antibiotic including the dosage and duration, no consistent documentation of the signs or symptoms the resident was experiencing, and no documentation of whether a culture was obtained or what organism was identified. Tracking and trending of infections was not provided by the facility for the time period from August 2024 through September 2025.</p> <p>During an interview on 10/03/25 at 7:05 PM, the Director of Nursing (DON) stated, My expectation is that the nurses follow an updated policy, fill out McGeer's criteria correctly and have the documentation in the EMR to include any testing and results that are needed to reflect the care of the resident.</p> <p>Review of McGeer's Criteria dated 11/05/24 revealed, . Table 2. Urinary Tract Infection (UTI) Surveillance Definitions Syndrome: UTI without indwelling catheter Criteria: 1. At least one of the following sign or symptom: Acute dysuria or pain, swelling, ., Fever or leukocytosis, and one or more of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency. If no fever or leukocytosis, then greater than 2 of the following: suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency 2. At least one of the following microbiologic criteria greater than or equal to 100,000 Colony Forming Units (CFU) per milliliter (mL) of no more than 2 species of organisms in a voided urine sample greater than or equal to 100 of any organism(s) in a specimen collected by an in-and-out catheter .</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy Antibiotic Stewardship Program dated 05/29/24 indicated, It is the guideline of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The program includes protocols and a system to monitor antibiotic use. i. Nursing shall assess residents who are suspected to have an infection and notify the physician. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses the [CDC's NHSN Surveillance Definitions, updated McGeer criteria, or.] to define infections. This outdated policy was the only policy for Antibiotic Stewardship provided by the facility.</p>		