STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525730	A. Building B. Wing	09/21/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on interview and record review, the facility did not ensure 1 of 1 allegations of abuse were immediately reported to the Administrator and State Survey Agency - Resident (R) 58. On 9/4/22 at 6:30 am, R58 was noted with an abrasion to the right knee and bruising to the right upper lip and cheek which were attributed to a fall. On 9/5/22, R58 was observed with facial bruising around the mouth and right eye, again attributed to a fall. On 9/6/22, R58's family informed Hospice nurse as well as RN (Registered Nurse) Unit Manager F they did not think the bruising was a result of falls, and that R58 was afraid of RN H who was alleged to be rude, rolling her eyes and yelling at R58's family. As of 9/19/22, Director of Nursing (DON) B was not aware of any allegations that R58's multiple bruises are not from R58 falling. As of 9/21/22, the facility did not immediately report this allegation to the State Agency. The facility did not report the results of an investigation to the State agency within 5 days of the incident. The facility should have submitted an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report (form F-62617) no later than 2 hours after the allegation was made. The facility should have submitted a Misconduct Incident Report (form F-62447) by 9/13/22. Findings include: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse and Neglect policy and procedure dated April 2020 documents, Reporting and Response: It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported per Federal and State law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency and adult protective services in accordance with State law through these established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility per agreement with the local law enforcement agency. R58 was originally admitted to the facility on [DATE] and began receiving hospice services on 08/16/22 due to a terminal diagnosis of combined systolic and diastolic congestive heart failure. R58 also has diagnoses that include Dementia, Epilepsy, and history of CVA. The Significant Change Minimum Data Set, dated dated [DATE], indicates that R58 has a BIMS score (Brief Interview for Mental Status) of 6, indicating severely impaired cognition. R58 is also noted to need 1 person, limited assistance with bed mobility and transfers, and needs the supervision of 1 person to walk in her room. R58 does not have any impairments in range of motion to the upper or lower extremities. Nursing note dated 09/04/22 at 6:30 a.m. indicates (R58) found sitting on side of bed on floor, gaze fixed up, disorientated times 4, very restless, reaching out into air and grabbing things. (R58) was transferred back into bed with 3 staff and mechanical lift. Abrasion noted to right knee and bruising to right upper lip and cheek. (R58) is unable to report what happened and just repeats,I need to go to get upstairs. Phone call to Hospice Nurse who states she will be in this morning to assess (R58) on change of condition/decline. Nurse Practitioner to be updated later this morning as well as family. The facility's falls investigation dated 09/04/22 at 5:00 a.m., states that the fall was unwitnessed in (R58's) room. New orders were given to give Ativan and Morphine every 1 hour until R58 settles down. Interventions in place at time of fall. Hospice note (hospice notes are a part of R58's entire medical record) dated 09/04/22 states that writer received call from answering service at 6:22 a.m. from RN at Ignite and R58 fell and there are other concerns. Orders given and writer to go to assess. Hospice note dated 09/08/22 - late entry for 09/05/22 routine visit for decline. Upon arrival (R58's) family member present at bedside. (R58) is in hospital bed unresponsive. (R58's) right side of face bruised around mouth and right eye. Fall happened this morning and RN spoke with staff who reports no injuries. Writer spoke with Ignite RN who stated she did not know how (R58) fell . MD notified and orders received to discontinue all medications other then comfort medications. Hospice note dated 09/06/22 states that (R58's) family member called stating that the bruise on (R58's) right cheek was worse than this morning and that her cheek was more swollen. Passed this information on to DCS (Director of Client Services). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice note dated 09/06/22 states that (R58) has multiple bruises to right eye, right cheek, right side of mouth, right wrist, and right knee. (R58) has had multiple falls including this morning. (R58's) family member explaining to writer what occurred around (R58's) falls and (R58) opens her eyes and asked her (family member) to stop and I don't want to get into trouble. Spoke with Asst. Chief Nursing Officer/ Unit RN Manager F who states she will look into the incident. Family member reports (R58) has had 5 falls since admission. Per facility staff, none were witnessed, staff states (R58) up walking when she fell however (R58) is up with the use of a mechanical lift to Broda chair. On 09/19/22 at 2:00 p.m., Surveyor interviewed Director of Nursing (DON) B in regard to R58 and the concerns brought forth by R58's family. DON B stated she was not aware of any allegations that R58's multiple bruises are not from her falling. DON B stated that RN Manager F had a lot of communication with R58's family and the family took a lot of pictures of the bruising. DON B provided Surveyor with a summary of concerns from R58's family. The document header states: (R58) complaints reported to me (RN F) on 9/6 from (R58's) family member. The document states RN H is rude and rolling eyes and yelling at family - Statement from RN H and educate on customer service. Guest (R58) is afraid of RN H and states, please don't hit me and now bruises on face - bruises documented in fall during assessment. Skin: bruise noted to right eye/cheek/above lip, bruise to right elbow and knee. The summary included a statement from RN H who answered the following question: Did guest fall during your shift between 9/2-9/5, if so what days and times?- RN H wrote no. There was no additional statement from RN H regarding interactions with (R58) or her knowledge of the bruises. On 09/20/22 at 2:00 p.m., Surveyor interviewed Unit RN Manager F regarding R58's family's concerns. RN F stated she did talk with the hospice nurse on Tuesday (09/06/22) after R58's fall. Family requested any documentation regarding the falls. R58's family did state they did not think the bruising was from the falls and wanted to know more about what happened. RN F states she went over the falls assessments with the family and showed them the bruising was documented post fall. Surveyor asked RN F if she conducted an investigation into R58's allegation that RN H is rude and R58 is afraid of her and stated to her, please don't hit me. RN Manager F stated she just talked with RN H and gave her education on customer service and told RN H that when she needs to go into R58's room to make sure she has another staff member with her. RN F stated that RN H did not work on the shift that the fall happened, the fall was 3rd shift and RN H works first shift. On 09/20/22 at 3:00 p.m., Surveyor interviewed Administrator A and DON B in regards to the allegation of potential abuse by RN H to R58. Surveyor asked if the facility had conducted a thorough investigation into the allegation of abuse and if they had reported it to the state survey agency within the required timeframe? DON B stated she would follow-up and provide additional information if they had it. On 09/21/22 at 10:07 a.m., Surveyor interviewed Social Services (SS) G regarding R58. SS G stated that R58 was very confused at the time of her falls. Surveyor asked if SS G was aware that R58's family had concerns about RN H and allege that R58 is afraid of RN H and stated please don't hit me. SS G stated that all the residents love RN H and they all trust her. SS G stated that she had no concerns about RN H and did not conduct any formal investigation other that just checking in on R58 like she does with all the residents making sure they are emotionally stable. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of the time of exit on 09/21/22, the facility was not able to provide any additional information that they had reported an allegation of abuse by RN H to R58 to the state survey agency within the required timeframe.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on interview and record review, the facility did not immediately investigate 1 of 1 Residents (R) reviewed for an allegation of potential abuse when facility staff became aware of the allegation (R58.) Facility staff became aware of an allegation of potential abuse of R58 when a family member expressed concerns to RN Manager F on 09/06/22. The family member identified RN H as the alleged perpetrator and the facility did not immediately start an investigation into the allegation and the facility did not prevent potential further abuse while the investigation was in progress. As of 09/19/22, Director of Nursing (DON) B was not aware of any allegations that R58's multiple bruises were not from R58 falling. Findings include: The Abuse and Neglect policy and procedure dated April 2020 documents, Investigation: It is the policy of this facility that all allegations and reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. R58 was originally admitted to the facility on [DATE] and began receiving hospice services on 08/16/22 due to a terminal diagnosis of combined systolic and diastolic congestive heart failure. R58 also has diagnoses that include Dementia, Epilepsy, and history of CVA. The Significant Change Minimum Data Set, dated dated [DATE] indicates that R58 has a BIMS score (Brief Interview for Mental Status) of 6 which indicates severely impaired cognition. R58 is also noted to need 1 person, limited assistance with bed mobility and transfers, and needs the supervision of 1 person to walk in her room. R58 does not have any impairments in range of motion to the upper or lower extremities. Nursing note dated 09/04/22 at 6:30 a.m. documents (R58) found sitting on side of bed on floor, gaze fixed up, disorientated times 4, very restless, reaching out into air and grabbing things. (R58) was transferred back into bed with 3 staff and mechanical lift. Abrasion noted to right knee and bruising to right upper lip and cheek. (R58) is unable to report what happened and just repeats,I need to go to get upstairs. Phone call to Hospice Nurse who states she will be in this morning to assess (R58) on change of condition/decline. Nurse Practitioner to be updated later this morning as well as family. The facility's falls investigation dated 09/04/22 at 5:00 a.m., states that the fall was unwitnessed in (R58's) room. New orders were given to give Ativan and Morphine every 1 hour until (R58) settles down. Interventions in place at time of fall. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice note (hospice notes are a part of R58's entire medical record) dated 09/04/22 states that writer received call from answering service at 6:22 a.m. from RN at Ignite and (R58) fell and there are other concerns. Orders given and writer to go to assess. Hospice note dated 09/08/22 - late entry for 09/05/22 routine visit for decline. Upon arrival (R58's) family member present at bedside. (R58) is in hospital bed unresponsive. (R58's) right side of face bruised around mouth and right eye. Fall happened this morning and RN spoke with staff who reports no injuries. Writer spoke with Ignite RN who stated she did not know how (R58) fell . MD notified and orders received to discontinue all medications other then comfort medications. Hospice note dated 09/06/22 stated that (R58's) family member called stating that the bruise on (R58's) right cheek was worse than this morning and that her cheek was more swollen. Passed this information on to DCS (Director of Client Services). Hospice note dated 09/06/22 states that (R58) has multiple bruises to right eye, right cheek, right side of mouth, right wrist, and right knee. (R58) has had multiple falls including this morning. (R58's) family member explaining to writer what occurred around (R58's) falls and (R58) opens her eyes and asked her (family member) to stop and I don't want to get into trouble. Spoke with RN Manager F who states she will look into the incident. Family member reports (R58) has had 5 falls since admission. Per facility staff, non were witnessed, staff states (R58) up walking when she fell however (R58) is up with the use of a mechanical lift to Broda chair. On 09/19/22 at 2:00 p.m., Surveyor interviewed Director of Nursing (DON) B in regard to R58 and the concerns brought forth by R58's family. DON B stated she was not aware of any allegations that R58's multiple bruises are not from her falling. DON B stated that RN Manager F had a lot of communication with R58's family and the family took a lot of pictures of the bruising. DON B provide Surveyor with a summary of concerns from R58's family. The document header states: (R58) complaints reported to me (RN Manager F) on 9/6 from (R58's) family member. The document states RN H is rude and rolling eyes and yelling at family. Statement from RN H and educate on customer service. Guest (R58) is afraid of RN H and states please don't hit me and now bruises on face - bruises documented in fall during assessment. Skin: bruise noted to right eye/ cheek/ above lip, bruise to right elbow and knee. The summary included a statement from RN H who answered the following question: Did guest fall during your shift between 9/2-9/5, if so what days and times? RN H wrote no. There was no additional statement from RN H regarding interactions with R58 or her knowledge of the bruises. On 09/20/22 at 2:00 p.m., Surveyor interviewed Unit RN Manager F regarding R58's family's concerns. RN F stated she did talk with the hospice nurse on Tuesday (09/06/22) after R58's fall. Family requested any documentation regarding the falls. R58's family did state they did not think the bruising was from the falls and wanted to know more about what happened. RN F states she went over the falls assessments with the family and showed them the bruising was documented post fall. Surveyor asked RN F if she conducted an investigation into R58's allegation that RN H is rude and is afraid of her and stated to please don't hit me. RN Manager F stated she just talked with RN H and gave her education on customer service and told RN H that when she needs to go into R58's room to make sure she has another staff member with her. RN F stated that RN H did not work on the shift that the fall happened, the fall was 3rd shift and RN H works first shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/20/22 at 3:00 p.m., Surveyor interviewed Administrator A and DON B in regards to the allegation of potential abuse by RN H to R58. Surveyor asked if the facility had conducted a thorough investigation into the allegation of abuse and what they did to prevent potential further abuse during the investigation. DON B stated she would follow-up and provide additional information if they had it. On 09/21/22 at 10:07 a.m., Surveyor interviewed Social Services (SS) G regarding R58. SS G stated that R58 was very confused at the time of her falls. Surveyor asked if SS G was aware that R58's family had concerns about RN H and alleged that R58 is afraid of RN H and stated please don't hit me. SS G stated that all the residents love RN H and they all trust her. SS G stated that she had no concerns about RN H and did not conduct any formal investigation other that just checking in on R58 like she does with all the residents making sure they are emotionally stable. As of the time of exit on 09/21/22, the facility was not able to provide any additional information that they had thoroughly investigated the allegation of potential abuse of R58 by RN H.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, interview, and record review, the facility did not provide the necessary treatment and services to prevent development of a pressure injury and promote healing for 2 (R59 and R62) of 2 Residents with pressure injuries. *R59 developed 2 unstageable pressure injuries to the left and right heel discovered on 09/19/22. On 09/19/22, a dressing was observed to R59's left foot dated 9/1. R59 complained of heel pain on 9/1 and a dressing was placed and not changed until brought to the attention of the facility by Surveyor. Licensed Practical Nurse (LPN) D did not document any heel pain from R59 or that a dressing was placed on his left foot. The facility was unaware of any skin impairment to R59 until it was brought to their attention on 09/19/22. This resulted in actual harm to R59. *R62 was admitted on [DATE] with a deep tissue injury to his left heel. Although Director of Nursing (DON) B was assessing the area as a deep tissue injury, another individual was incorrectly inputting the assessment data into the computerized wound assessment as a blister/other. The facility was not aware of this data entry error until questioned by Surveyor. R62 was observed to have a deep tissue pressure injury to his left heel. Surveyor observed R62's left heel lying directly on the mattress. R62's care plan incorrectly identified the wound as a blister. In addition, R62's care plan did not address the need to offload R62's heels until 09/19/22 and did not address the use of boots. As of 09/20/22 the deep tissue injury has decreased in size. Findings include: 1. On 9/20/22 the facility's policy and procedure titled, Skin Policy and Procedure dated 3/20 was reviewed and read: The nurse will conduct a full-body skin assessment for each resident weekly to ensure no risks have developed. Care planning for pressure ulcers will include specific interventions to prevent development of pressure ulcers and/or treat existing pressure ulcers including pressure redistribution/relief including heel protection. Approaches to manage and monitor pain. R59 was admitted to the facility on [DATE] with diagnoses that included Quadriplegia and Malnutrition. R59 was also admitted with a Stage 3 pressure injury to his left buttock that healed on 8/30/22. R59's information indicated he makes decisions for himself. On 9/20/22 R59's admission MDS (Minimum Data Set) dated 8/18/22 was reviewed and indicated R59 had a Brief Interview for Mental Status (BIMS) score of 15 indicating R59 had fully intact long and short-term memory. The MDS also indicated R59 was at risk for developing pressure injuries. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/19/22 at 11:45 am, R59 was interviewed in his room. R59 was lying in his bed and indicated he had a sore on his left foot and nobody had looked at it or changed the dressing in about 3 weeks. R59 indicated his heel did not hurt and both feet were observed to be elevated on pillows and gripper socks were on both feet. Certified Nursing Assistant (CNA) E then came in the room and removed R59's gripper socks. A dressing was observed to R59's left heel that was approximately 50% covered with dried reddish-brown drainage. When CNA E lifted R59's left foot, the dressing had moved exposing R59's left heel and blood was observed dripping onto R59's pillow that was under the foot. A wound was observed to the left foot. The dressing on R59's left foot was dated 9/1 on PMs. This was verified by CNA E. CNA E then held up R59's right foot and a discolored area was observed to the foot. On 9/19/22 at 11:55 AM, Director of Nurses (DON) B came into R59's room and indicated R59 had no pressure injuries at that time. DON B observed R59's feet and indicated she was unaware of the pressure injuries. DON B observed the date on the bandage of 9/1 on PM shift. On 9/19/22, R59's pressure injury measurements were reviewed dated 9/19/22 at 1:04 PM which read: left heel, pressure, facility acquired, unstageable, scant serosanguineous (blood mixed with clear fluid) drainage, 100% deep maroon, 2 centimeters (cm) long by 3 cm wide, no depth. Right heel, pressure, facility acquired, unstageable 100% deep maroon, 2.5 cm long by 3 cm wide, no depth. On 9/19/22 at 1:15 PM, LPN D was interviewed and indicated she put the dressing on R59's left foot on 9/1/22 because he was complaining of pain to the foot. LPN D indicated she looked at the foot and saw intact skin to R59's left heel. LPN D indicated she should have made a note in R59's chart about placing the dressing but was not sure if she did. On 9/19/22, R59's medical record was reviewed and no documentation of the bandage on R59's left foot or complaints of foot pain were found. There was no evidence that R59's physician was notified of any pressure injuries or treatment for pressure injuries to his heels prior to Surveyors observation of R59's pressure injuries on 9/19/22 at 11:45 am. On 9/19/22 at 10:30 AM R59's care plan for potential for skin impairment with a date of 8/15/22 was reviewed and read: R59 has a potential for skin impairment related to impaired mobility. Interventions included: ensure that heels are elevated while lying in bed. A care plan for actual impairment to skin integrity related to bilateral heel pressure injuries was not added until 9/19/22 after the surveyor brought the pressure injuries to the facilities attention. On 9/20/22, the 24 hours communication sheets that would have included R59 were reviewed from the timeframe of 9/2/22 to 9/18/22 and did not indicate any pain, dressing, or impairment of either of R59's heels. DON B indicated when she provided the communication sheets that the sheet from 9/1/22 could not be found. On 9/20/22, R59's skin risk assessments dated 9/5/22 and 9/12/22 were reviewed and indicated R59 was at high risk for pressure injury development with a score of 10 (10-12 = high risk). On 9/20/22, R59's weekly skin check sheets dated 9/3/22, 9/10/22, and 9/17/22 all completed by Registered Nurse (RN) C were reviewed and indicated R59 had no skin issues new or old. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 9/20/22 at 1:02 PM, RN C was interviewed and indicated she took off R59's dressing to his left foot when she did the skin checks on 9/3/22, 9/10/22, and 9/17/22 and his skin was intact. RN C indicated she didn't know what she did after she removed the dressings. Surveyor informed RN C that the dressing observed on R59's left foot was dated on 9/1 and consisted of a kerlex wrapped around the ankle and foot. RN C indicated she could not remember or answer any further. On 9/21/22 at 12:30 PM, DON B was interviewed and indicated that she was not aware of any standard of practice of applying a padded dressing to a resident to relieve pain. DON B indicated any pain should be documented and communicated to the next shift for follow up. The above findings were shared with the Administrator and DON at the daily exit meeting on 9/20/22. Additional information was requested if available. None was provided. 21855 2. On 9/19/22 at 10:57 AM, Surveyor observed R62 laying in bed. R62 was laying on their right side with their bare feet directly on the mattress. R62 was queried about the left heel. R62 was not aware of the area, nor had any concerns. R62's medical record was reviewed by Surveyor. R62 was admitted to the facility on [DATE]. The Wound Assessment of the left heel, completed on 9/8/22, indicates an intact blister measuring 2 cm (centimeter) by 3 cm (centimeter), with a pressure ulcer scale for healing (Push) score of 8. The Push score ranges from 0 to 17 with higher scores reflecting a more severe ulcer. Included in this assessment is a colored picture of the wound. Surveyor observed the picture and observed what appeared to be a flat irregular discoloration of the left heel wound with Betadine on it. The picture did not show an open area or a blister. The Admission MDS (Minimum Data Set) completed on 9/13/22 indicated a deep tissue injury on the left heel measuring 2 cm by 3 cm. Surveyor spoke with DON (Director of Nursing) B on 9/22/22 at 1:45 pm for clarification of left heel wound. According to DON B, R62 was admitted with a deep tissue injury, and this has been consistent since admission. The Wound Assessment drop down box was clicked as other and blister, rather than as a deep tissue injury. DON B stated this was an error in the point click care data entry classification. DON B reported the area has been assessed as a deep tissue injury every week since admission, as supported by weekly pictures and measurements. DON B does the wound assessments, and another staff does the data entry. DON B was not aware of the data entry error of identifying the deep tissue injury as an intact blister until it was questioned by Surveyor. R62's Plan of Care for the left heel blister was initiated 9/8/22. Surveyor noted the care plan addresses the wound on the left heel as a blister and not as a deep tissue injury. The care planned interventions do not include off-loading of the left heel until 9/19/22. The care planned interventions also do not address the use of boots. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525730	A. Building B. Wing	09/21/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor spoke with DON B on 9/22/22 at 1:45 pm. DON B stated upon admission R62 had heel boots and to float heels, which were not indicated on the Care Plan. DON B reported R62 does move feet and kicks off the pillow and doesn't like heel boots. R62 does utilize proper footwear and nutrition to promote healing. R62 has a standard pressure reduction mattress. Surveyor noted R62 received physician ordered treatment of Betadine since admission on 9/8/22. On 9/20/22 at 9:25 AM, Surveyor observed R62's pressure injury treatment with DON B. R62 was sitting up in a wheelchair. R62 has an intact deep tissue injury on the outer aspect of the left heel. The 9/20/22 assessment which included colored pictures of the area indicated the measurement was 1.5 by 1.5 centimeters, indicating the area has decreased in size since admission. The physician ordered treatment of Betadine was applied. DON B was queried regarding preventative measures. DON B was not aware that off-loading of the heels was not on the plan of care. Surveyor also shared their observation of R62's heels resting against the mattress. On 9/20/22 at 3:00 PM at the facility Exit Meeting, Surveyor shared the concerns with R62's pressure injury interventions.