STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525179	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of Kenosha (the)	3100 Washington Rd Kenosha, WI 53144

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on record review, interview, and facility policy review, the facility failed to ensure there was a physician's order for oxygen therapy for one of two residents (Resident (R) 3) reviewed for oxygen therapy. The lack of physician's orders for oxygen therapy could lead to inappropriate oxygen therapy and medical compromise. Findings include: Review the facility's undated policy titled, Oxygen Administration, undated, revealed Oxygen will be safely administered per physician's orders .Procedure: If oxygen is continued beyond 24 hours, obtain a physician order. Review of R3's undated Admission Record located in the Profile tab of the electronic medical record (EMR) revealed the resident was most recently readmitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD). Review of R3's 5-day Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/18/24 and located under the MDS tab of the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. Continued review of the MDS revealed the resident was not assessed as using oxygen during the assessment period. Review of R3's Care Plan dated 07/12/24 and located under the "Care Plan" tab of the EMR revealed a focus area for chronic obstructive pulmonary disease with interventions that included to Give aerosol or bronchodilators as ordered .Monitor for difficulty breathing on exertion, Monitor for signs/symptoms of acute respiratory insufficiency: anxiety, confusion, shortness of breath at rest, cyanosis, somnolence. The Care Plan did not include oxygen therapy as an intervention. Review of R3's Physician Orders located under the Orders tab of the EMR, revealed no order for oxygen therapy. Review of R3's Progress Note dated 07/21/24 and located in the EMR under the Progress Notes tab, indicated the resident was sent out 911 (emergent) to the hospital for low oxygen saturation of 77% .PRN (as needed) albuterol was given which increased oxygen saturation to 85% .oxygen increased from 2L (liters) to 5L with a positive response in oxygen sat to 91%. (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
	525179	A. Building B. Wing	08/28/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a pulmonary note dated 07/23/24 located in the EMR under the Misc tab revealed R3 was initially admitted without oxygen therapy but due to oxygen saturations in the 80s, R3 was tried on oxygen on 07/15/24. The note indicated during the physician evaluation R3 was using 3L of oxygen. R3 reported to the pulmonologist that he felt better with the oxygen and was continuing to use it unless it fell off. During an interview on 08/27/24 at 2:19 PM the Director of Nursing (DON) stated the pulmonologist had indicated in a progress note to continue monitoring oxygen saturations and continue using supplemental oxygen. The DON stated the oxygen order did not get processed.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 15189 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents medications were administered in accordance with their policy for one of three residents (Resident (R) 8) reviewed for medication administration out of 20 sampled residents. Specifically, R8 was ordered to be administered his medications via a gastrostomy tube (g-tube). The resident was administered his medications as a cocktail (administer more than one medication at a time); however, there was no physician order for the medications to be administered as a cocktail. This placed the resident at risk for his G-Tube to become clogged. Findings include: Review of the facility's policy titled, Medication Administration-Gastrostomy Tube, dated 05/19/22 revealed Use liquid preparations whenever possible. Check with the pharmacist if in doubt about availability of medication in liquid form or whether tablets are crushable. Enteric-coated medications, sublingual tablets, and sustained release medications should never be crushed. If more than one medication is being given at a dosing time, administer each medication separately, flushing the tube with approximately 10 ml of tepid water between medications, or enough to clear the tubing, Tablets will be finely pulverized and dispersed well in tepid water . Review of R8's Medication Administration Record (MAR) dated August 2024 and located under the Orders tab of the electronic medical record (EMR) revealed R8 had the following medication orders: Docusate Sodium Oral Liquid 50 milligrams (mg)/5 milliliters (ml) , give 10 ml via g-tube two times a day for constipation Keppra Oral Solution 100 mg./ml, give 10 ml via g-tube two times a day for seizure disorder Famotidine Oral Tablet 20 mg., give 20 mg. via g-tube three times a day for gastroesophageal reflux disease (GERD) Guaifenesin Oral Syrup 100 mg./5ml, give 15 ml via g-tube four times a day for cough Observation and interview on 08/28/28 at 9:00 AM of Licensed Practical Nurse (LPN) 5 administering R8 his medications revealed the LPN measured 10 ml of Docusate sodium and poured it into a plastic cup. Continued observation revealed LPN5 then measured two more liquid medications (Keppra and Guaifenesin) and poured them both into the plastic cup with the Docusate sodium. LPN5 then crushed the Famotidine tablet and added the crushed medication to the plastic cup with the liquid medications. The LPN was stopped prior to administering the medication and asked about the facility's policy and procedure for administering more than one medication via the G-Tube. LPN5 stated that she was not aware of the facility's policy and procedure. The medications were not administered at that time. During an interview on 08/28/28 at 5:40 PM, the Director of Nursing (DON) stated it was her expectation LPN5 would have followed the facility's policy for medication administration via the g-tube.