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	10/24/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on observation, interviews, and facility policy review, the facility failed to ensure water temperatures were maintained at safe and comfortable temperatures with the potential for burn-related injuries or for residents to receive showers at uncomfortable temperature levels for three of four units (South unit, North unit, and [NAME] unit) affecting 36 of 81 residents in the facility. Findings include: Review of the facility's policy titled, Water Temperature Policy with an effective date of 10/22/24 revealed the acceptable range for water temperatures was between 110 degrees Fahrenheit (F) and 120 degrees F. During an interview on 10/21/24 at 12:31 PM a resident wishing to remain anonymous stated the water was cold when they assisted her with a shower but lately it has been working. During an interview on 10/22/24 at 1:46 PM a resident wishing to remain anonymous stated the water at his bathroom sink had been very hot lately. During an interview on 10/22/24 at 10:25 PM a resident wishing to remain anonymous stated the staff gave him a pan of water to take a bed bath with and it was so hot he could not hold his hands in it. During observations and interviews on 10/22/24 at 1:18 PM the water temperature in the south unit shower room was 81 degrees F. The Maintenance Employee (ME) verified the water was too cold to take a comfortable shower. The water temperature was tested in the sinks in the bathrooms located from seven resident rooms on the south unit. The water temperatures fluctuated from 94 degrees F to 124 degrees F. The water temperature was over 120 degrees F at two of the seven-bathroom sinks checked. The water temperature was 124 degrees F in room one and 123-degrees F in room two. Review of the floor plan and the Census Sheet revealed the south unit had a total of 17 resident rooms each with a bathroom containing a sink and a toilet off of each room. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations and interviews on 10/22/24 at 1:30 PM the water temperatures were obtained on the north unit. The water temperature in the shower in the north central shower room was 125 degrees F. This was the only shower on the north unit. The ME stated the water temperature should measure 110 degrees F and verified it was hot to touch. The water temperature on the north unit was obtained at the sinks in 16 resident bathrooms. The water temperatures in five of the 16 rooms were over 120 degrees F. The water temperatures fluctuated between 80.2 degrees F and 139 degrees F. The water temperature in room [ROOM NUMBER] and room [ROOM NUMBER] was 125 degrees F; the water temperature at the sink in room [ROOM NUMBER]'s bathroom was 135 degrees F and at the sinks in room [ROOM NUMBER] and room [ROOM NUMBER] was 139 degrees F. Review of the Census Sheet revealed 22 residents resided on the north unit at the time the temperatures were obtained therefore this could have the potential to effect all 22 residents as a result of the shower being over 120 degrees F. During observations on 10/22/24 at 2:00 PM the water temperatures on the west unit were tested in 16 rooms. The water temperatures fluctuated between 106 degrees F and 124 degrees F. The shower in the shower room on the west unit measured 106 degrees F. The water temperature in seven of the 16 rooms tested over 120 degrees F. The water temperature at the sink in the bathroom from room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] were 122 degrees F; the water temperature in room [ROOM NUMBER] was 124 degrees F; and room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER] had a water temperature of 123 degrees F. During an interview on 10/22/24 at 2:55 PM, ME was asked if he checked the hot water temperatures in the facility. He stated he checked the water temperature at the hot water tanks once per week. When asked if he checked them in the resident rooms, he stated he randomly checked them every couple of weeks, but he did not write it down. During interviews on 10/22/24 at 3:08 PM, the water temperatures were shared with the Administrator, Regional Nurse Consultant (RNC) 1 and Regional Nurse Consultant (RNC) 2. When a copy of the water temperature policy was requested, the Administrator stated they did not have a water temperature policy. The monitoring logs for the water temperatures were requested and a notebook titled Hot Water Tank Temp's Daily Log was provided. Review of the notebook titled Hot Water Tank Temp's Daily Log revealed the water temperatures were logged daily for the Domestic Tank 1 on the west unit, Domestic Tank 2 on the rehab unit, Domestic Tank 3 on the rehab unit, the water tank for the kitchen and the water tank serving the laundry. The logs did not have temperatures of the water temperatures in the showers, or the sinks located in the resident bathroom. At 3:56 PM, the Administrator verified the water temperatures were not monitored in the shower rooms nor at residents' bathroom sinks. She provided a list showing the facility had four shower rooms and 81 resident bathrooms. She stated she would have expected the maintenance department to check water temperatures regularly.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03115 Based on observations, menu review, and interviews, the facility failed to ensure the menu was followed for all the diets listed on the menu spreadsheet for 81 of 81 residents who receive food from the facility. Failure to follow the spread sheet had the potential to result in weight loss and for residents to feel hungry. Findings include: Review of the Client List Report dated 10/22/24 and provided by the facility, revealed the facility had 60 residents on regular consistency diets, 13 residents on mechanical soft consistency diets, and eight residents on puree consistency diets. The facility did not have any residents who were on tube feedings and did not receive their meals from the dietary department. During lunch observations on the north, south and west units on 10/22/24 from 11:50 AM to 12:40 PM, three unidentified residents stated they often did not get enough food during the meals. During an observation and interview on 10/22/24 at 11:29 AM, the [NAME] was observed serving the noon meal from the steam table in the kitchen. She stated she was serving the residents on all the regular consistency diets and mechanical soft diets a #6 (5.3 ounce) scoop of Chicken Cacciatore and 3-ounces of carrots. The pasta was mixed in with the chicken Cacciatore. She stated she was giving the residents on the puree diet a 4-ounce scoop of puree chicken and a 4-ounce scoop of puree carrots. She stated she did not serve the purees chicken cacciatore because a lot of them did not like tomato, so she just gave all the purees a 4-ounce scoop of puree chicken instead. She was observed serving these portions to all residents on regular consistency diets, mechanical soft consistency diets, and puree consistency diets unless they received alternate food items. Review of the paper menu spreadsheet titled Daily Spreadsheet .Week 4 Tuesday provided by the facility, revealed the residents on all regular and mechanical soft texture diets were supposed to receive 6-ounces of Chicken Cacciatore, 4-ounces of Penne pasta, and 4-ounces of butter carrots. Per the menu the residents on puree textured diets were supposed to receive 8-ounces of puree chicken cacciatore, 4-ounces of puree penne pasta, and 4-ounces of puree carrots. During an interview on 10/22/4 at 11:39 AM, the Dietary Manager (DM) verified the cook was not following the menu for any of the diets. The DM verified the cook should have been serving 4-ounces of penne pasta and 6-ounces of chicken cacciatore and she was only serving 5.3-ounces of the pasta and chicken cacciatore mixed together to the residents on regular and mechanical soft diets. The DM verified she should have been serving 4-ounces of carrots and was only serving 3-ounces of carrots to residents on regular and mechanical soft consistency diets. The DM verified she should have been serving 8-ounces of puree chicken cacciatore and 4-ounces of puree penne pasta and she was only serving 4-ounces of puree chicken to the residents on puree consistency diets. During an interview on 10/22/24 at 1:03 PM, the Administrator stated she would have expected the menu to be followed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 Based on observations, interviews, and facility policy review, the facility failed to maintain a functioning call system with auditory alarms to alert staff when a resident called for assistance for one of three call light systems (North station). This could result in residents' needs/care being delayed unnecessarily for the 22 residents in the North Hall. Findings include: Review of the facility's policy titled, Call Light Policy revised 01/28/23 revealed, Purpose: To respond to resident's needs and requests in a timely manner .2. Make sure the call light is plugged in and in good working order. Call light system defects will be reported to the Maintenance Department for servicing . During an interview on 10/21/24 at 3:04 PM, Certified Medication Tech (CMT) 1 was behind the nursing station on the North wing and she stated the call light panel behind the nursing station did not work. When asked how long it had not worked, she stated she did not know and I would have to talk to maintenance . Observation on 10/21/24 at 5:42 PM revealed room [ROOM NUMBER]'s call light was on over the door to the room. The panel at the nurse's station did not light up or make a noise. Staff saw the light on over the door and answered it quickly. Observation on 10/22/24 at 1:30 PM revealed the call light for room [ROOM NUMBER] was on over the door, however the light on the panel in the nursing station did not light up or make noise. Maintenance Employee (ME) was present at the time and confirmed the light and alarm did not work properly at the North nurse's station. During an observation and interview on 10/23/24 at 12:09 PM, ME was working on the annunciator for the call system at the North nurse's station. He confirmed it did not work and said he had no idea how long it had been broken. During an interview on 10/23/24 12:15 PM, Registered Nurse (RN) 3 was in the nurse's station during random call light audits. RN3 stated .It's supposed to make noise too . RN3 stated it had been broken about a month ago and she reported it to Maintenance. During an interview on 10/23/24 12:18 PM, Certified Nurse Aid (CNA) 1 stated the call system quit making noise a month ago and maintenance just needed to put a work order in for it. During an interview on 10/23/24 at 3:14 PM the Administrator verified the call light on the north unit at the nursing station was still not alarming audibly. She stated she did not fill out a work order, but she did tell the maintenance man. She stated she checked the work orders and could not find a work order for it, so she submitted one. The Administrator stated the lights still worked to alert staff, but the sound was broken. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 4:10 PM ME stated that the call light stopped alarming about a month ago and it was reported but no work order had been submitted. ME stated he called a couple of different companies, and they told him they could not fix the issues because the system was too old. He stated he did find someone to come to the facility on Friday that had a low voltage alarm like on the call light system.