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	01/07/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observations, interviews, and record review, the facility failed to ensure appropriate door closure with an operating door latch for one of six residents (Resident (R) 4) reviewed for privacy of 12 sample residents. This failure resulted in the potential to affect resident safety, security, and privacy. Findings include: Review of the Admission Record located under the Profile tab in the electronic medical record (EMR) revealed R4 was admitted on [DATE] with diagnoses that included bilateral primary osteoarthritis of knee. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R4 was cognitively intact. During an interview on 01/07/25 at 11:22 AM, R4's door was observed to have a towel and pillowcase draped over the inside corner of the door. R4 stated, That's to keep it shut because it doesn't stay closed. It's been like that since September. A CNA [Certified Nurse Aide] came up with the idea of putting the linens up there and it works. The biggest problem I had was when the door didn't stay closed, others could see me on the commode. When the resident was asked if she had reported the problem with the door, R4 stated, Yeah, I think, they all know about it. During an observation on 01/07/25 at 11:30 AM, the door upon closing revealed the latch did not engage with the strike plate. During an interview on 01/07/25 at 2:15 PM, the Administrator confirmed that the door did not remain closed in its frame stating, It's probably related to the weather, expanding and contracting. During an interview on 01/07/25 at 3:30 PM the Unit Manager/Registered Nurse (RN1) discussed where the maintenance work orders were located and how the orders were submitted. RN1 said she was not aware of the problem with R4's door not staying closed.

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

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

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interviews, record review, and review of the facility policy, the facility failed to ensure a fingerstick blood sugar test (FSBS), and insulin was documented as administered, per the physician's order for one of three residents (Resident (R) 3) reviewed of 12 sample residents. This failure placed the resident at risk for serious medical consequences. Findings include: Review of the facility's policy titled, Medication Errors, revised February 2023, revealed .Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines .Resident's Condition .If the resident's condition requires rigid control .or monitoring of lab values .Drug Category .If the medication is from a category that usually requires the resident to be titrated to a specific blood level .To prevent medication errors and ensure safe medication administration, nurses should verify the following information .Right medication, dose, route, and time of administration, right resident and right documentation . Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE] with diagnoses that included type one diabetes (juvenile diabetes) with ketoacidosis and coma (a process which forms toxic acids known as ketones in the blood or urine which can lead to a coma due to high levels of ketones.) Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/02/24 revealed R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 was cognitively intact and had been administered insulin during the seven-day observation period. Review of the December 2024 Medication Administration Record (MAR) located in the Orders tab of the EMR, revealed the following medications were not documented as having been obtained or administered for R3: 1. Insulin Lispro [fast-acting insulin] 100 UNIT/ML [Unit/Milliliter] Solution pen-injector. Inject 4 units subcutaneously three times a day for DM [diabetes mellitus] Start Date-12/05/24. There was no documentation that R3 was administered this medication on 12/7/24 at 8:00 AM or 12:00 PM. 2. Insulin Lispro Subcutaneous Solution Pen-injector 100 UNIT/ML. Inject as per sliding scale: if 150-199 = 1 unit; 200-249 = 2 units; 250-299 = 3 units; 300-349 = 4 units; 350-400 = 5 units over 400 administer 6 units, subcutaneously three times a day for DM. Start Date 12/05/24. There was no documentation to show that an FSBS was obtained or insulin administered on 12/07/24 at 8:00 AM and 12:00 PM. Review of the Nursing Progress Notes located in the Progress Notes tab of the EMR did not show any documentation on 12/07/24 that R3 had been assessed for the FSBS or insulin administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/24 at 2:15 PM, the Director of Nursing (DON) stated she had contacted Registered Nurse (RN) 3 regarding the blank documentation on the MAR for the insulin and FSBS. The DON stated, When I spoke to [RN3] on 01/07/24 regarding the identified blanks for the insulin and FSBS, [RN3] stated, 'I get so busy I forget to document' but did not indicate whether the insulin or FSBS had been obtained or administered for [R3]. The DON further stated, It is my expectation that medications are to be administered, as ordered, by the physician and is documented on the MAR.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on interviews, record review, and review of facility policy, the facility failed to ensure the Medication Administration Record (MAR) and/or treatment administration record (TAR) was complete and accurate for two of 12 sample residents (Resident (R) 10 and R7) reviewed for accurate documentation. - R10's MARs were not accurately documented to show medications werev administered according to physician orders. -R7's TARs were not accurately completed to show consistent application of ordered treatments to R7's pressure injuries. Findings include: Review of the facility's policy titled, Medication Administration-General Guidelines, revised January 2018, revealed .The individual who administers the medication dose records the administration on the resident's MAR/eMAR [electronic medication administration record] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications . Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease (ESRD), dementia, and diabetes. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/24/24 revealed R10 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R10 was moderately cognitively impaired. Review of the December 2024 eMAR revealed the following medications were not signed out as having been administered to R10: 1. Amoxicillin-Pot Clavulanate Oral Suspension Reconstituted [an antibiotic] 250-62.5 MG [milligram]/5ML [milliliter]. Give 10ml by mouth in the morning for PNA/UTI [pneumonia/urinary tract infection] for 5 days-Start Date 12/18/24. There was no documentation to show that R10 was administered the antibiotic on 12/22/24, as ordered. 2. Donepezil HCL [hydrogen chloride] Oral Tablet 5 MG. Give 5mg by mouth at bedtime for Dementia-Start Date 12/17/24. There was no documentation to show the medication was administered on 12/19/24, as ordered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Famotidine Oral Tablet 20 MG. Give 20mg by mouth at bedtime for GERD [gastric esophageal reflux disease]-Start Date 12/17/24. There was no documentation to show that R10 was administered the medication on 12/19/24, as ordered. 4. Ferrous Sulfate [an iron supplement]. Give 650mg by mouth three times a day for supplement-Start Date 12/18/24. There was no documentation to show the medication was administered at 12:00 PM and 8:00 PM, as ordered. 5. Guaifenesin-DM [Dextromethorphan] Oral Syrup 100-10MG/5ML. Give 5ml by mouth three times a day for cough-Start Date 12/18/24. There was no documentation to show the medication was administered at 12:00 PM on 12/19/24, as ordered. 6. Renvela Oral Packet 0.8GM. Give 800mg by mouth three times a day for CKD/Dialysis [chronic kidney disease]-Start Date 12/18/24. There was documentation to show the medication was administered at 12:00 PM on 12/19/24, as ordered. 7. Ipratropium-Albuterol Inhalation Solution [a breathing medication] 0.5-2.5 (3) MG/3ML. 3ml inhale orally four times a day for SOB [shortness of breath]-Start Date 12/27/24. There was no documentation to show this was administered at 8:00 PM on 12/19/24, as ordered. During an interview on 01/17/25 at 2:15 PM, the Director of Nursing (DON) stated that she contacted Registered Nurse (RN) 5 regarding the blanks in documentation. The DON stated that RN5 was to have administered the 6:00 AM dose on 12/22/24 but was passed onto the day shift nurse, RN4 who stated that she did give the medication, however she did not document this on the MAR. In addition, the DON stated that Licensed Practical Nurse (LPN) 3 told her that the medications were administered on 12/19/24, however, she did not document this on the eMAR. The DON stated, My expectation is the medications are to be documented on the eMAR after being administered. 2.) Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R7 was admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of two limbs), morbid obesity, and a sacral pressure ulcer. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/24/24 revealed R7 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 was cognitively intact and had one Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) on his sacrum (tailbone area). Review of the Physician Orders, dated 10/24, located in the Orders tab of the EMR, revealed the following wound care orders for R7's pressure ulcers: -Cleanse wound to left buttock with normal saline, pat dry, skin prep to peri wound, apply Iodosorb gel, followed by calcium alginate, and cover with bordered gauze, daily and PRN [as needed]. Start Date: 09/24/24 Review of the Treatment Administration Record (TAR) revealed there was no documentation to show that the treatment for R7's left buttock was administered on 10/04/24 and 10/31/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cleanse wound to right lateral ankle with normal saline, pat dry, skin prep to peri wound, apply lodosorb to wound bed, followed by calcium alginate, and cover with bordered gauze daily and PRN. Start date: 10/22/24. Review of the TAR revealed there was no documentation to show that the treatment for R7's right ankle wound was administered on 10/31/24. -Cleanse wound to right lateral hip with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, and cover with bordered gauze daily and PRN. Start Date: 09/24/24. Review of the TAR revealed there was no documentation to show that the treatment for the right hip was administered on 10/04/24. -Cleanse wound to sacrum with normal saline, pat dry, skin prep to peri wound, apply lodosorb gel to wound bed, followed by calcium alginate, and cover with ABD [large pad dressing] and tape daily and PRN. Start Date: 09/24/24. Review of the TAR revealed there was no documentation to show that the treatment to R7's sacrum was administered on 10/04/24 and 10/31/24. -Cleanse wound to right lateral ankle with normal saline, pat dry, skin prep to peri wound, apply collagen powder to wound bed, followed by calcium alginate, and cover with bordered gauze daily and PRN. Start Date: 10/26/24. Review of the TAR revealed there was no documentation to show that the treatment for R7's right ankle wound was administered on 10/04/24. Review of the Physician Orders, dated 11/24, located in the Orders tab of the EMR, revealed the following wound care orders for R7's pressure ulcers: -Cleanse wound to left buttock with normal saline, pat dry, skin prep to peri wound, apply lodosorb gel, followed by calcium alginate, and cover with bordered gauze, daily and PRN [as needed]. Start Date: 09/24/24 Review of the TAR revealed there was no documentation to show that the treatment to R7's left buttock was administered on 11/04/24. -Cleanse wound to sacrum with normal saline, pat dry, skin prep to peri wound, apply lodosorb gel to wound bed, followed by calcium alginate, and cover with ABD [large pad dressing] and tape daily and PRN. Start Date: 09/24/24. Review of the TAR revealed there was no documentation to show that the treatment to R7's sacrum was administered on 11/04/24. Cleanse wound to right lateral ankle with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, followed by calcium alginate, and cover with bordered gauze daily and PRN. Start Date: 11/05/24. Review of the TAR revealed there was no documentation to show that the treatment to R7's right ankle was administered on 11/15/24. -Cleanse wound to left buttock with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, and cover with bordered gauze daily and PRN. Start Date: 11/12/24. Review of the TAR revealed there was no documentation to show that the treatment to R7's left buttock was administered on 11/15/24. -Cleanse wound to right upper lateral leg with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, and cover with bordered gauze daily and PRN. Start Date: 11/12/24. Review of the TAR revealed there was no documentation to show the treatment for R7's right upper leg was administered on 11/15/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cleanse wound to sacrum with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, followed by calcium alginate, and cover with ABD and tape daily and PRN. Start Date: 11/05/24. Review of the TAR revealed there was no documentation to show the updated treatment to R7's sacrum was administered on 11/15/24. Review of the Physician Orders, dated 12/24, located in the Orders tab of the EMR revealed the following wound care orders for R7's pressure ulcers: -Cleanse wound to left buttock with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, and cover with bordered gauze daily and PRN. Start Date: 11/05/24. Review of the TAR revealed there was no documentation to show that the treatment to R7's left buttock was administered on 12/05/24, 12/06/24, 12/07/24. -Cleanse wound to right lateral ankle with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, followed by calcium alginate, and cover with bordered gauze daily and PRN. Start Date: 11/05/24. Review of the TAR revealed there was no documentation to show the treatment for R7's right ankle was administered on 12/05/24, 12/06/24, 12/07/24, 12/19/24, 12/20/24, 12/21/24, and 12/22/24. -Cleanse wound to sacrum with normal saline, pat dry, skin prep to peri wound, apply medihoney to wound bed, followed by calcium alginate, and cover with ABD and tape daily and PRN. Start Date: 11/05/24. Review of the TAR revealed there was no documentation to show that R7's treatment to his sacrum was administered on 12/05/24, 12/06/24, 12/07/24, 12/19/24, 12/20/24, 12/21/24, and 12/22/24. During an interview on 01/07/25 at 12:20 PM, R7 was asked if he was receiving wound care daily. R7 stated, Yes. R7 was asked if he left the facility often to go out into the community. He stated, Yes. R7 was asked if wound care was done before he left the facility. He stated, Well, if I don't get it, then they are supposed to make up for it later, but not sure. I do think it's healing though. During an interview on 01/07/25 at 1:22 PM, the Director of Nursing (DON) stated, If [R7] is out [of the facility] on a shift and not back by the end of the shift, then the nurses are to pass on the information to the next shift on what needs to be done. The DON further stated that she tried to call [Registered Nurse (RN) 3] to ask why the treatments were not documented as administered but RN3 was not available. The DON stated, My expectation is that medications and treatments are to be documented as administered at the time that it was done or document that the resident was out of the facility at the time the treatment was to be administered. The next shift nurse would then use a PRN order for the particular wound treatment and document that it was administered. During a follow-up interview on 01/27/25 at 2:15 PM, the DON stated that she was able to contact RN3 and ask about the missing documentation regarding R7's treatments. The DON stated that RN3 said, I get too busy, I forget to sign out for medications and treatments.