STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525431	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clairidge House	1519 60th St Kenosha, WI 53140

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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 - Some	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. 03115 Based on observation, record review, policy review, and interviews, the facility failed to ensure the residents' environment was clean, sanitary, and homelike. This had the potential to result in the spread of infection; residents being injured as the result of a loose toilet seat; a decline in residents' self-esteem. This affected five (Resident (R) 26, R32, R23, R9, and R22) of 41 residents in the facility. Findings include: 1. On 10/15/24 at 2:57 PM; on 10/16/24 at 9:00 AM, 12:28 PM, and 3:38 PM; on 10/17/24 at 9:36 AM and 3:30 PM; and on 10/18/24 at 11:00 AM there was an unlabeled urinal on the floor of R26 and R32's bathroom and the pull cord on the bathroom call light was soiled with a brown substance. The urinal was lying on its side to the back of the toilet. On 10/17/24 at 3:30 PM the Social Service Director (SSD) verified the urinal was on the floor and the call cord was visibly soiled. On 10/28/24 at 11:00 AM the Maintenance Director verified the observation. On 10/17/24 at 9:36 AM and 3:30 PM a soiled incontinent brief with bowel movement on it was observed on the floor in R26 and R32's bathroom. On 10/17/24 at 3:30 PM the SSD verified the soiled incontinence brief was on the floor. She stated the nursing staff, or housekeeping should have cleaned it up. On 10/18/24 at 1:34 PM, Certified Nurse Aid 5 (CNA5) stated R26 uses the bathroom independently and R32 needed assistance with toileting and incontinence care. Review of R26's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 09/22/24 provided by the facility revealed a Brief Interview for Mental Status (BIMS) score was 13 out of 15 indicating he was cognitively intact. The MDS indicated R26 was independent with toilet hygiene, personal hygiene, and walking. The assessment stated he was continent of bowel and bladder. Review of R32's quarterly MDS with an ARD of 08/10/24 provided by the facility revealed the resident had a BIMS score of 14 out of 15 indicating he was cognitively intact. The MDS indicated R32 required moderate assistance with toilet hygiene, and he was occasionally incontinent with urine and frequently incontinent of bowel. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 10/15/24 at 12:01 PM; 10/16/24 at 12:34 PM and 3:36 PM; on 10/17/24 at 9:40 AM and 3:30 PM; and on 10/18/24 at 11:02 AM and 2:32 PM the bathroom between R9 and R23's rooms had a strong smell of urine. The floor was visibly soiled and was sticky to the feet. There was a one-inch brown smear on the wall just across from the toilet. The call cord in the bathroom was soiled with a brown substance. On 10/17/24 at 3:30 PM the SSD verified the observations. On 10/18/24 at 11:02 PM the Maintenance Director verified the observations. On 10/18/24 at 2:32 PM CNA5 stated both R9 and R23 are capable of using the bathroom independently. Review of R23's quarterly MDS with an ARD of 09/04/24 provided by the facility revealed a BIMS score of 00 out of 15 indicating he was severely cognitively impaired. The MDS indicated R 23 was independent with walking and transfers and required supervision and verbal cues for toileting. Review of R9's quarterly MDS with an ARD of 08/14/24 provided by the facility revealed a BIMS score of 15 out of 15 indicating she was cognitively intact. The MDS indicated that she was independent with toileting hygiene, transfers, and she was frequently incontinent of urine and occasionally incontinent of bowel. She was dependent on a wheelchair for mobility. 3. On 10/15/24 at 2:08 PM R9 stated the toilet seat in the bathroom of her previous room was loose and the privacy curtain was soiled. She stated the facility moved her to the room she was currently in so they could clean the room and fix the items that needed repair. She stated once they moved her, she liked the room and chose to remain in the room they moved her to. Review of the floor plan and the census sheet revealed R22 was moved into R9's previous room. On 10/15/24 at 2:15 PM; 10/16/24 at 3:36 PM; and 10/17/24 3:30 PM, the toilet seat in R22's bathroom was loose and moved side to side, when lightly pushed. The privacy curtain was soiled in a three-foot by four-foot area along the bottom of the curtain. On 10/17/24 at 3:30 PM, the SSD verified the curtain was soiled and the toilet seat was loose. On 10/17/24 at 3:30 PM, R22 verified the curtain was soiled and the toilet seat was loose. Review of R22's significant change MDS located in the MDS tab of the electronic medical record (EMR) with an ARD of 09/03/24 revealed a BIMS score of 10 out of 15 which indicated he had moderate cognitive impairment. The MDS indicated he was independent with toilet hygiene, personal hygiene, and transferring. He utilized a wheelchair for locomotion. Review of the facility policy titled, Housekeeping-Routine (occupied) Room Cleaning dated 09/20 revealed it was the facility's policy to maintain rooms in a clean and sanitary manner. The protocol stated to complete thorough room cleaning quarterly, at move out, and as needed. The policy stated to report any defective equipment or repairs needed to your supervisor via the maintenance request book. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Housekeeping - Toilet and Bathroom Cleaning dated 03/23 revealed it was the facility policy to maintain bathrooms in a clean and sanitary manner. The policy stated routine bathroom and toilet cleaning should occur daily. The policy stated to report any defective equipment or repairs needed to your supervisor via the maintenance request book.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one resident out of 28 sampled residents (Resident (R) 36) had an accurate Minimum Data Set (MDS) assessment. Failure to code the MDS correctly regarding R36's feeding tube, could lead to inaccurate assessment and care planning of the resident. Findings include: Review of the RAI Manual dated 10/01/19, indicated, . information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy by the IDT [interdisciplinary team] completing the assessment." Review of Section K of the RAI manual indicated, DEFINITIONS PARENTERAL/IV [Intravenous] FEEDING Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). FEEDING TUBE Presence of any type of tube that can deliver food/nutritional substances/ fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes. Review of R36's Face Sheet under the Face Sheet tab in the electronic medical record (EMR) revealed an admitted [DATE] with medical diagnosis that included Gastrostomy status [feeding tube]. Review of R36 admission MDS with and Assessment Reference Date (ARD) 02/28/24, the quarterly MDS with an ARD of 05/06/24, and the quarterly MDS with an ARD of 08/06/24, revealed Section K lacked documentation of R36's use of a feeding tube. During an interview on 10/18/24 at 12/05 PM, the MDS Coordinator confirmed R36 has had a feeding tube since admission, however, does not get any nourishment through the feeding tube. The MDS Coordinator verbalized the feeding tube should have been coded on all the MDS assessments that have been completed since his admission. The MDS Coordinator confirmed the RAI manual was used to complete the MDS forms when assessing the residents. During an interview on 10/18/24 at 10:30 AM, the Director of Nursing (DON) confirmed R36 has a feeding tube, and the feeding tube should be documented in the MDS assessments.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident with an indwelling urinary catheter had a physician's order for the use of an indwelling urinary catheter for one of two residents (R)34) reviewed for indwelling urinary catheter care. As a result of this deficient practice, the resident had the potential for harm by staff performing interventions or actions without a physician's order. Findings include: Review of R34's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, revealed an admitted [DATE] with medical diagnosis of neurogenic bladder. Observation on 10/15/24 at 3:30 PM, R34 had an urinary catheter tubing sticking out of the bottom of his pant leg, connected to a urinary collection bag. Review of R34's Care Plan under the Care Plan tab in the EMR revealed, Has Foley [indwelling urinary catheter] due to spinal cord injury with subsequent development of neurogenic bladder with the intervention to .change Foley PRN [as needed] Indwelling catheter and maintain patency of equipment . Review of R34's physician's orders in the EMR under the Physician' Orders tab revealed a physician's order dated 03/17/24 documenting Urinary Treatment: monitor urinary output. Reason for indwelling Foley: Neurogenic bladder, every shift document output with intake all shifts. Physician's orders lacked documentation of the type of indwelling catheter, diameter size and balloon size, frequency of changing the catheter and any interventions to maintain patency. Review of the physician orders dated 10/24 revealed no order for an indwelling urinary catheter. During an interview on 10/17/24 at 9:52 AM, the Minimum Data Set (MDS) Coordinator reviewed R34's physician orders and confirmed there was no physician's order for the indwelling urinary catheter and interventions for care by the nursing staff. During an interview on 10/18/24 at 10:24 AM, the Director of Nursing (DON) reviewed R34's physician orders and confirmed there was no order for the indwelling urinary catheter. The DON stated that there should be an order, not just to measure and empty the collection bag. Review of the facility's policy titled Catheter Management, revised 6/24 revealed, .if an indwelling catheter is determined necessary and medically justified . Review of the facility provided textbook Clinical Nursing Skills and Techniques authored by [NAME], [NAME], [NAME] Ottendorf, and [NAME], with a copywrite date of 2022, documented on page 999, .after identifying the [resident] with two identifiers, review the residents EHR (electronic health record) health care providers orders .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interview, record review and policy review, the facility failed to ensure a resident with a feeding tube (gastrostomy tube) had a physician's order for the care and management of the feeding tube for one of one resident (Resident (R)36) reviewed for gastrostomy care. As a result of this deficient practice, the resident had the potential for harm by staff performing interventions or actions without a physician's order. Findings include: Review of R36's Face Sheet under the Face Sheet tab in the electronic medical record (EMR) revealed an admitted [DATE] with medical diagnosis of Gastrostomy status [feeding tube]. Review of the Care Plan under the Care Plan tab in the EMR documented, Alteration in nutrition (less than body requirements) history of severe protein malnutrition, past history of significant weight loss, with recent improvement /rebound, wounds, has g-tube [gastrostomy tube] refuses to use, dysphagia [difficulty swallowing] due to a failed swallow study on 10/10/24. Review of R36's Medication Administration Record (MAR) revealed for the months of June 2024 and October 2024 documented an intervention to flush tube with 120 milliliters (ml) of water via enteral tube [feeding tube] daily. Review of R36's Physician's Orders tab in the EMR lacked documentation of an order to flush the feeding tube. During an interview on 10/28/24 at 9:53 AM, Registered Nurse (RN) 2 stated that R36 has a feeding tube, and the evening shift performs the flush as listed on the MAR daily. RN2 confirmed there was no physician's order for the feeding tube to be flushed daily. During an interview on 10/18/24 at 10:30 AM, the Director of Nursing (DON) reviewed R36's physician orders and confirmed there was no order for daily flushing of the feeding tube. The DON stated that there should be an order. Review of the facility's policy titled, Nutrition-Gastric Feeding Tubes, dated 01/24 revealed, Note the order in the MAR regarding tube feeding . consistent with the physician's order.

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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** 15879 Based on observation, record review, interview, and policy review, the facility failed to ensure one Resident (R)41 out of three residents observed with a medication in a cup on the bedside table was administered his medication when the nurse dispensed the medication. This failure had the potential to place the resident at risk for health decline. Findings include: Review of the facility's policy provided by the facility titled, Medication Administration Scheduling Guidelines dated 5/19 revealed, .the facility requires that drugs be administered by the nurse until the care planning team has the opportunity to obtain necessary information of the residents' ability to safely self-administer medication. During an observation on 10/17/24 at 9:00 AM, with Register Nurse (RN)2, R41 was in his room and a pill was in a medication cup on the resident's bedside table. RN2 asked R41 if the night shift nurse had awakened him to give his medication. R41 stated, no the nurse did not wake him up during the night to give his medication and that he had not been given any medication earlier that morning. Review of R41's Face Sheet, located under the Face Sheet tab of the electronic medical record (EMR) revealed R41 had an admitted to the facility on [DATE] with a diagnosis of diabetes. Review of R41's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR revealed an assessment reference date (ARD) of 08/05/24 revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated intact cognition. Review of R41's comprehensive care plan, dated 08/08/24 and located under the Care Plan tab in the EMR revealed a problem was listed for self-care deficit and one of the interventions was for administration of medication and to watch for side effects. Review of R41's Assessments tab under the Assessments tab in the EMR revealed there was no assessment done for self-administration of medication. During an interview on 10/17/24 at 9:10 AM, RN2 revealed the medication should not have been left in the room. During an interview on 10/17/24 at 10:00 AM, the Director of Nursing (DON) stated that it was not okay for a nurse to leave any medication in a resident's room. The DON stated the nurse should witness the resident taking the medication and then sign the MAR as given. The DON revealed they have residents who have dementia and could have taken the medication and swallowed it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 15879 Based on record review, document review, policy review, and interviews, the facility failed to ensure controlled substances were under double lock for one of two medication rooms (second floor), and that the individual controlled count sheets reflected the signatures of the nurses who had administered the narcotics to the residents for three of fourteen residents (R) 32, R37 and R24). This failure had the potential for controlled substances to be diverted. Findings include: 1. Review of the facility's policy, provided by the facility, titled Controlled Substance revised on 4/21 and reviewed on 7/24 revealed, purpose was to ensure appropriate and consistent procedures for safeguarding controlled substances are followed from delivery through the actual administration and/or destroying of medication. The policy further revealed the protocol to follow was all controlled substances will be counted by two nurses at each shift change. The ongoing nurse will count the controlled substances and the off going nurse will verify the count from the individual controlled substances count sheet and count the number of the actual controlled substances count sheet themselves to ensure that they are all in place. Both nurses will sign the individual controlled substances count sheets and the Master Controlled Substance record in the appropriate space. Both nurses will visualize the controlled substance to the count sheets. If a discrepancy is found the pharmacy, Director of Nursing (DON), Nursing Home Administrator (NHA) and the medical director are to be notified immediately, and an investigation begun. The policy further revealed, controlled substances requiring refrigeration must be double locked and count with all others. During review of the controlled substance count sheets dated 10/24 with Licensed Practical Nurse (LPN)2 revealed the controlled substance count sheets had missing signatures for 10/13/24 and 10/14/24 that verified the counts were correct. Review of the Master Control Substance record for October 2024 revealed 33 blanks where the number of cards should have been indicated and six blanks where a signature should have been that indicated each nurse signed off on the sheet as it was correct. Review of R32's individual count sheets for the narcotic Oxycodone 15 milligram (mg), R37's individual count sheet for the narcotic Tramadol 50 mg, and R24's individual count sheet for the narcotic Hydrocodone/APAP 5-325 mg revealed the amount of total pills on the sheet matched the numbers of pills available on the punch card. However, the individual count sheet for R32 was missing the nurse's signature on 10/15/24 who had removed the narcotic from the punch card and administered the narcotic to the resident; for R37's sheet, 10/16/24 was missing the nurse's signature and for R24's sheet, 10/16/24 was missing the nurse's signature. Review of the October 2024 Medication Administration Records (MARs) for R32, R37 and R24 revealed that there was documentation for 10/15/24, 10/15/24, and 10/16/24 that the nurse did not sign out for the narcotic on the individual count sheet, that the narcotic was administered to the resident with the nurses' initials and date and time of administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 12:45 PM, LPN2 revealed stated that she had not yet signed the controlled substances that she had given that morning and proceeded to sign the individual count sheets as we spoke. LPN2 stated the second shift nurse did not sign out the controlled substances they had given that night (10/15/24), so the night shift nurse put the number on the sheet, but did not sign the number and they went on and counted. LPN2 revealed she thought the second shift nurse had just forgotten to sign them out, but she did not verify that by looking at the MAR. LPN2 revealed she assumed the second shift nurse had administered it. LPN2 revealed her and the night shift nurse did not notify the DON of the discrepancy. During an interview on 10/16/2024 at 1:16 PM, the DON revealed she had not been notified that the individual controlled substance sheets for R32, R37 and R24 were missing nurses' signatures when the narcotic was administered. The DON revealed she should have been notified because an incorrect count could have indicated drug diversion. During an interview on 10/16/24 at 1:16 PM, the DON reviewed R32, R37 and R24's MARs for each controlled substance and found they were signed as given on the MAR. The DON revealed the Master Control Substance record should have been signed by the nurses coming on and going off to work and there were multiple omissions of signatures. During an interview on 10/18/24 at 10:15 AM, the stated that nurses counting the controlled substances should not assume a medication was given unless confirmation had been done. The nurses should have called the nurse who had omitted their signature and notified the DON. 2. During an observation on 10/16/24 at 1:47 PM, Registered Nurse (RN)2 unlocked the medication room door on the second floor and opened the refrigerator that was unlocked and contained Ativan. Observation revealed the lock for the refrigerator was on top of the refrigerator. RN2 walked out of the medication room without locking the refrigerator. During an observation on 10/16/24 at 1:55 PM, further revealed RN2 unlocked the medication room door and verified the refrigerator was not locked. During an interview on 10/16/24 at 1:55 PM, RN2 stated she had been in the refrigerator earlier in the shift and forgot to lock the refrigerator and that she did not lock it when we had gone in the medication room. RN2 revealed the refrigerator had Ativan stored in it and that the refrigerator should be under double lock and it was not. During an interview on 10/17/24 at 3:34 PM, the DON revealed the medication room, and the refrigerator should be under double lock and if the refrigerator was not locked then it was a single lock and that is not their policy. During an interview on 10/18/24 at 10:15 AM, the Administrator revealed controlled substances should be under double lock.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 03115 Based on record review, document review, and staff interview, the facility failed to designate a person to serve as the Director of Food and Nutrition Services. Failure to designate a person had the potential to result in food not being prepared, stored, or served in a sanitary manner with the potential to result in food borne illness. This had the potential to affect all 41 of 41 residents residing in the facility. Findings include: On 10/15/24 at 10:34 AM, during the initial tour of the dietary department, Cook1 and Dietary Aid (DA)1 were working in the kitchen and when asked who the Dietary Manager/Director of Food Services was they both stated they did not have one. Cook1 stated she used to be the interim supervisor until they hired one. They stated a Director of Dietary was hired and then quit and they have not had a supervisor since he left. Interview on 10/15/24 at 4:10 PM, the Corporate Clinical Consultant and the Administrator stated the facility had a consultant Dietitian who provided consulting services once a week. They stated they did not have a person designated as the Director of Food and Nutrition Services. Per interview they were actively recruiting for a Certified Dietary Manager (CDM) and were having problems finding a qualified person. The Corporate Clinical Consultant provided a document titled (name of facility) Dietary Manager Recruitment and interview with the Administrator and Corporate Clinical Consultant revealed Cook1 was designated as the interim Director of Dietary on 11/01/22 when the last CDM was terminated. They stated that they continued to advertise and interview potential candidates without any success. Per the document and review of [NAME] 1's personnel file, Cook1 was enrolled in the CMS course on 06/2023. On 05/2024, she decided not to complete the course and additional advertising was conducted. Per the report they hired a CDM on 07/15/24 and he terminated his employment on 08/23/24. The interview revealed they had not designated a Director of Food and Nutrition Services since 08/23/24 and they continued to place ads, and had interviewed two candidates in September 2024. Review of Cook1's personnel file revealed she did not meet the requirements to be designated as the Director of Food and Nutrition Services. On 10/18/24 at 10:45 AM, telephone interview was conducted with the Registered Dietitian (RD) who stated that she only does the clinical side of nutrition services and did not inspect the kitchen for potential sanitation problems. She stated she provides services about once a week and often she completes her visits virtually. Review of a list of hours she worked since 09/01/24 revealed she worked one hour on 09/07/24, two hours on 09/13/24, 3.25 hours on 09/17/24, four hours on 09/26/24, and two hours virtually via computer on 10/10/24. Review of the facility's Job Description for the Food Service Manager revealed for the Qualification section, the Food Service Manager must be a Certified Dietary Manager.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03115 Based on observation, staff interviews and policy/procedure review, the facility failed to ensure the low temperature dishwasher sanitizer was maintained at a level required to sanitize the dishes. Failure to ensure the sanitizer level of the dishwasher was at the required level had the potential to result in food borne illness or the spread of infections for all 41 of 41 residents residing in the facility. Findings include: On 10/15/24 at 10:34 AM, the sanitizer in the low temperature dishwasher was checked by Dietary Aid (DA)1. The chlorine test strip did not change color indicating the chlorine sanitizer was at zero parts per million (ppm). The sanitizer was checked three times and each time the test strip did not turn colors. DA1 was asked if she tested it prior to washing the breakfast dishes and she stated she had and stated the test strip had not turned colors prior to using it to wash the breakfast dishes. On 10/15/24 at 1:05 PM, DA1 was observed running the soiled plates from the lunch meal through the dishwasher. After running two racks of dishes through the dishwasher, DA1 was asked to test the sanitizer level. DA1 used the chlorine test strip and the test strip did not change colors indicating the chlorine sanitizer was at zero ppm. DA1 continued to run the soiled dishes through the dishwasher after the sanitizer level was checked and found to be zero parts per million. On 10/15/24 at 1:06 PM the Administrator was informed the low temperature dishwasher sanitizer level was zero ppm. At 1:08 PM, the sanitizer level was checked again with the chlorine test strip and showed zero ppm. The Administrator verified it was zero ppm and informed the dietary staff to stop using the dishwasher until the problem was resolved. The Administrator stated that he expected dietary staff to test the dish machine and ensure it was the correct level of chlorine before they use it. Review of the facility policy/procedure titled, Dish Machine - Low Temperature/Chemical Status Procedure dated 1/24 stated the chlorine should be no less than 50 ppm and no greater than 100 ppm when washing the dishes. The policy stated if the temperature or chlorine ppm were not within acceptable limits fix the problem immediately and record on the temperature sheet what you did to fix the problem. If the temperature or chlorine ppm is still out of normal range, DO NOT USE the dish machine and contact maintenance or the dietary manager immediately for further action.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525431	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clairidge House	1519 60th St Kenosha, WI 53140

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on staff interviews, record reviews, and document review, the facility failed to ensure the staff were prepared and educated for the care of one resident (Resident (R)26) with a portable infusion pump delivering chemotherapy drugs through a surgically implanted port. As a result of this deficient practice, the residents and staff had the potential for harm and/or injury due to lack of knowledge for: the care of the pump and tubing; awareness of the hazards of the chemotherapy drug and potential exposure risks with a leak or spill; and biohazard containment of a chemotherapy drug if a leak/spill did occur. Findings include: Review of R26's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, revealed an admitted [DATE] with medical diagnoses that included chronic viral hepatitis C, Human immunodeficiency virus (HIV) disease, and new rectal cancer diagnosis. Review of the 24-Hour Nursing report sheet (not a part of the resident medical record) dated 10/13/24, provided by the facility, documented R26 returned from a clinic appointment at 4:57 PM with an infusion pump. The 24-hour Nursing report dated 10/14/24 documented, NOC [night] shift: no issues with chemo/pump, DAY shift: lethargic and weak from treatment of new chemo pump and PM [evening] shift: no complaints related to pump. Review of R26's Nursing progress notes dated 10/13/24 in the EMR under the Nursing Progress notes tab lacked documentation the resident returned from treatment with a new chemotherapy infusion pump. Nursing progress notes dated 10/14/24 and 10/15/24, lacked documentation of the presences of the pump. Nursing progress notes on 10/16/24 documented at 4:46 AM and 6:24 AM chemo pump intact and no issues. Nursing progress note dated 10/16/24 at 1:52 PM documented, [Physician's] office called to request order for Ambulatory pump. Request for order to list medication to be give, awaiting response. The Nursing progress note dated 10/16/24 at 3:05 PM, documented a conversation with the resident reports port was accessed this week and chemo started via pump which he had in his lap as going to radiation [appointment]. He did not know much but it was chemo. Dressing intact covering port needle, no leaking with insertion site, free of redness or swelling. Pump running-green light on .call placed to oncology clinic regarding recent access of port an infusion running. Nursing is monitoring the device and site with no abnormal findings. Have requested clinic staff to assist with clarification needed to ensure collaboration-coordination of care related to port, need to clarify what is medication infusing and management of port site-dressing/access etc. to ensure coordination and all applicable interventions are in place. Requested return call. Review of R26's Care Plan located in the EMR under the Care Plan tab revealed on 10/16/24, R26 will be receiving cancer treatments both chemo and radiation on a scheduled basis chemo via pump, continuous at facility. Has a radiation schedule with radiation and management per oncologist at radiation oncology cancer center at an acute hospital. R26 has an implanted port to left chest wall for chemo infusions. (continued on next page)

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	525431	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clairidge House	1519 60th St Kenosha, WI 53140

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician's order provided by the facility on a separate paper dated 10/16/24 at 8:56 PM, documented, Infu-System CADD [Continuous Ambulatory Delivery Device] Ambulatory Pump for chemotherapy treatment continuous IV [intravenous] three times a day AM [morning] PM, NOC check dressing and IV site also FOR: chemotherapy treatment Administration instructions: If dressing becomes loose, tape around it with medical tape. If any fluid leaks around it or under the dressing, stop the pump and call MD [Medical Director]. The physician's order lacked interventions for actions to treat any leaking/spill as a hazardous material and to take appropriate safety precautions. During an interview on 10/16/24 at 12:03 PM, Licensed Practical Nurse (LPN) 2 when asked about R26's ambulatory pump, she stated that she did not know what it was for or what was needed for the care of the pump. During an interview on 10/16/24 at 12:05 PM, the Director of Nursing (DON) explained the pump's purpose was for chemo drug administration. The DON confirmed the staff had not been educated about the chemotherapy drug infusion. During an interview on 10/16/24 at 12:36 PM, the Corporate Clinical Consultant confirmed the staff had not been educated prior to R26's pump arriving at the facility and specifically the nurse caring for R26 and that LPN2 had not been educated about the pump, it's purpose, precautions to be taken [hazardous material] or interventions to implement. During an interview on 10/18/24 at 11:06 AM with the Administrator and the Corporate Clinical Consultant, they confirmed the facility assessment revised 08/06/24 did not include providing care for residents receiving on site chemotherapy drugs as the care the facility provided for the residents. The Corporate Clinical Consultant verbalized the facility was unaware of the resident with the chemotherapy infusion prior to the resident returning from the appointment. The Corporate Clinical Consultant stated the clinic did not communicate the special needs for the resident until inquiries were made by the facility. Review of the facility assessment revised 08/06/24 documented, care provided for resident who are receiving chemotherapy and radiation therapy. Under the heading Staff training/education and Competencies indicated, Staff training/education programs and competencies necessary to provide the support and care needed for our resident population.