STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525125	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENOSHA ESTATES REHAB AND CARE CENTER	1703 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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not promptly resolve grievances for 1 of 1 resident (R4). R4 was discharged from the facility on 11/23/19 and none of his clothes/belongings were sent with him. On 11/23/19, R4's Responsible Party (RP) - F asked the facility to mail R4's clothes/belongings to him. As of 12/3/19, the belongings had not been sent to R4. RP-F had to again call the facility and request that the facility mail R4's belongings to him. Findings include On 1/15/20 the state agency received a complaint from RP - F that noted the following; R4 had been discharged from the facility on 11/23/19 without his clothes or belongings. RP - F had to contact the facility 2 times before his clothing were mailed to him on 12/3/19. R4 is [AGE] years old and has a [DIAGNOSES REDACTED]. RP - F is R4's responsible party. R4's discharged from the facility on 11/23/19. On [DATE] at 1:56 PM, RP - F was interviewed via the telephone. RP - F said that on 11/22/19, the day prior to his discharge, she had packed up all of R4's belongings. They were contained in two boxes and left in his room. One box contained clothing and the other box contained personal hygiene items. RP - F was not at the facility on 11/23/19 when R4 was discharged from the facility. RP - F said that on 11/23/19, she received a call from the new facility that R4 had been discharged to. The new facility said that R4 had arrived with only the clothes on his back and no other belongings had been sent. RP - F called the facility that day and requested that the facility mail his belongings overnight to his new facility. RP - F said that she was told that NHA - G, the administrator at the time, would have to approve the expense to do this. RP - F said that she did not know who she had spoken to at the facility. RP - F said that she was unable to take the belongings to R4, because he had been discharged to a facility in his hometown that was both 4.5 hours away from her and the facility. RP - F said that after the initial call on 11/23/19, she had made several calls to the facility and had asked to speak with NHA - G and Social Services Director (SSD) - H. RP - F said that neither NHA - G nor SSD - H returned her calls. RP - F said that on 12/3/19, the new facility had contacted her and informed her that no belongings had been received for R4 from the facility. RP - F said that she had to again call the facility to send R4's clothes to him at his new facility. RP - F said that after she called again on 12/3/19; the facility mailed his clothing/belongings to R4. RP - F said that R4 had called her on 2 occasions and was upset about his missing belongings. RP - F said that R4 wore clothes from the new facility's Lost and Found from 11/23 - 12/5/19, when R4's clothing arrived at the new facility. On [DATE] at 9:26 PM, SSD - H was interviewed. SSD - H said that R4 had been discharged from the facility on a Saturday and she was not working on that day. SSD - H said that she had not been notified that R4's clothing/belongings had not been sent with him until 12/3/19. SSD - H said the facility then mailed the belongings on 12/3/19.
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** Based on observation, interview, and record review the facility did not provide proper foot care for 1 of 1 resident (R3). R3's toenails were very long and in need of trimming. Findings include On 2/13/20 the state agency received an anonymous complaint that R3's had not been provided with foot care. R3 was admitted to the facility for short-term rehab on 12/10/19 after having fallen at home. R3 had a fractured right knee that had an immobilizer and a fractured left wrist that had a brace. Her 12/17/19 Admission Minimum Data Set (MDS) noted that R3 was cognitively intact. The medical record indicated that R3 was responsible for herself and made her own decisions. On [DATE] at 10:58 am, R3 was interviewed about her foot care. R3 pulled off her socks and her toenails were observed to be very long and in need of trimming. R3 said that her toenails were so long that they hurt. R3 said that her toenails had not been trimmed since she was admitted to the facility. R3 said that Social Services Director (SSD) - H had told her that the podiatrist would see her on [DATE]. R3 said that the podiatrist did not see her that day. On [DATE] at 2:42 PM, Director of Nursing (DON) - B was interviewed. DON - B said that the nurse is responsible for trimming residents' toenails if the resident is diabetic. If the resident is not diabetic, then the nursing assistants can trim a resident's toe nails. DON - B provided a copy signed by R3 on 12/19/19 that she had agreed to receive podiatry services from an outside agency that came to the facility. However, the facility did not have documentation that the podiatrist had seen R3. When asked, DON - B could not explain why nursing staff had not trimmed R3's toenails, as R3 was not diabetic. DON - B did provide copies of the facility's Comprehensive CNA Shower Review forms indicating that R3's toenails were in need of trimming on 1/7/20 and 1/21/20. However, the shower sheet did not confirm that R3's nails had been cut on those days.
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** Based on observation, interview, and record review, the facility did not provide 1 of 1 resident (R3) requiring respiratory care with [MED]gen services in accordance with her care plan. R3's [MED]gen tubing was not changed in accordance with the physician's orders [REDACTED]. R3 was admitted to the facility for short-term rehab on 12/10/19 with a [DIAGNOSES REDACTED]. Her 12/17/19 Admission Minimum Data Set (MDS) noted that R3 was cognitively intact. The medical record indicated that R3 was responsible for herself and made her own decisions. R3 had the following physician's orders [REDACTED]. Change the [MED]gen tubing on the concentrator and portable tank every 5 days. On [DATE] at 10:53 am, R3 was interviewed and asked if her [MED]gen tubing was being changed. R3 had two pieces to her [MED]gen tubing. R3 said that the lower portion of her tubing had not been changed since 1/21/20, as indicated by the tape attached to the tubing. There was indeed a piece of tape attached to the lower part of the tubing with the date, 1-21. R3 said that upper part of the tubing, that was shorter and was attached to the nasal cannula that went into her nose, had not been changed in over 1 month. On [DATE] at 11:40 am, Director of Nursing (DON) - B was asked to review R3's [MED]gen tubing. DON - B said that R3 had a two part [MED]gen tubing system and the expectation would be that both parts are changed every 5 days in accordance with the physician's orders [REDACTED]. On [DATE] at 1:00 PM, DON - B was interviewed and said that she was in the process of calling nursing staff to determine if the [MED]gen tubing had been changed, as documented. DON - B did state that R3 was responsible for herself and that her answers appeared credible. On [DATE] at 2:10 PM, DON - B said that she had interviewed 2 of the 3 nurses who had documented on the TAR that R3's [MED]gen tubing had been changed. LPN - I said that on 2 occasions she had put the upper part of the [MED]gen tubing on R3's nightstand with a note to change in the morning because R3 was sleeping. RN - J said that she had changed the tubing, but it could not be confirmed if RN - J had changed both the lower and upper portions of the tubing.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**

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

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.

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F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Based on observation, interview, and record review the facility did not provide a safe and functional environment for residents, staff, and public on the East Unit. This had the potential to affect 23 residents, who were living on the East Unit at the time. * The facility's roof was leaking above the East Nurses' station, making the area unusable. It was tarped off with plastic. * The leaking roof also caused 2 smoke alarms at the East Nurses's and an adjacent fire alarm pull station to be inoperable. Findings include: The state agency received an anonymous complaint on 1/21/20 alleging the following; The ceiling was cracked and falling in above one of the nurses' stations. The fire alarms do not always work. 1. On 3/5/20 at noon, the East Nurses station was observed. The nurses' station was tarped off with plastic sheets from floor to ceiling, on two sides. The station was open on the third side, providing limited accessibility to the station. (The fourth side of the nurses's station was blocked off by a wall.) Licensed Practical Nurse (LPN) - C, who works on the East Unit, said that the area was being repaired due to problems with the ceiling leaking. LPN - C said that nursing staff were not using the station and that the conference room was serving as a replacement for the East Nurses' Station. At this time, there was no active leaking from the ceiling. On 3/5/20 at 3:30 PM, Nursing Home Administrator (NHA) - A stated that the facility had plans to fix the leaking roof. NHA - A said that he was informed by various contractors that the roof could not be repaired until the snow was gone and the roof was dry. NHA - A estimated that the facility's roof would be repaired sometime in the Spring. On [DATE] at 9:45 am, the East Nurses station area was again observed. The carpet surrounding the nurses station, on the two sides that had been tarped off, was saturated with water/liquid. The carpeted area on the inside of the nurses station was also saturated. The entire area that was wet measured approximately 10 by 15 feet. At the time there was no active leaking from the ceiling. It had rained the previous night, and it appeared that the roof had leaked into the East Nurses Station, saturating the carpet in the area. 2. On [DATE], the facility was unable to provide information, in a timely manner, that their fire alarm system was operable and that residents were safe. On [DATE] at 1:00 PM, Director of Environmental Services (DES) - D was interviewed regarding the fire alarms. DES - D said that in January of 2020 the roof was leaking above the East Nurses Station. This caused 2 smoke alarms above the East Nurses Station and 1 fire alarm pull station in the area to be inoperable. DES - D said that the facility's fire alarm system was operable, with the exception of the 2 smoke alarms and 1 fire alarm pull station. On [DATE] at 8:20 am, DES - D was asked to provide documentation showing that the facility's fire alarm system was currently operable and residents were safe. DES - D said that she did not have this information and that she only had a quote from the facility's fire protection company to repair the non-functioning parts. DES - D said that she would attempt to obtain this information. On [DATE] at 9:19 am, the surveyor met with NHA - A and DES - D. The surveyor requested a time-line of the problems with the fire alarm system, to include the action taken to ensure the system was operable and that residents were safe. NHA - A said it would take some time to gather this information because the problem initially occurred when there was a different NHA at the facility. It was not until 1:39 PM on [DATE] that the facility was able to provide documentation that showed their fire alarm system was operable and that residents were safe. NHA - A, DES - D, and Regional Maintenance Director (RMD) - E were interviewed and the following information was provided; On 1/27/20 at 3:18 am, the facility's fire alarm system was activated. The local fire department was dispatched to the facility. DES - D was called and arrived at the facility. The local fire department informed DES - D that there was no fire, smoke, etc. and that the system was setting off false alarms. The fire department told DES - D to disable the fire alarm system, until it could be repaired. Additionally, the fire department directed DES - D to begin a Fire Watch until the system was repaired. DES - D said that the Fire Watch began immediately. The facility called in 1 additional staff person to perform the Fire Watch duties on each shift. These staff had no other duties, other than to monitor the building for signs of fire and smoke. Any signs of fire and smoke were to be reported immediately to the local fire department. The facility provided a copy of the Fire Watch Log Sheet for 1/27/20. Staff had monitored the building for 24 hours from 1/27/20 at 3 am until 1/28/20 at 3 am. Neither fire nor smoke were noted. DES - D said that she had called the facility's fire protection company immediately, when the fire department was at the facility and told DES -D that the system needed to be repaired. The fire protection company said they would come as soon as possible and arrived at the facility at 8 am. The fire protection company said that two smoke detectors and 1 fire alarm pull station had been damaged by the leaking roof and were causing the system to alarm when there was no fire/smoke. The fire protection company removed the 2 smoke detectors and said that the facility was safe because there were other smoke detectors within 20 feet of the two smoke alarms that were being removed. The fire system company also disabled the fire alarm pull station and said that the facility was safe because: there were other pull stations in the area, the facility had a sprinkler system, and the sub-panel could also be utilized. On 3/27/20, the fire protection company put the facility's fire alarm system back on and indicated that the system was fully operational. As of [DATE] the facility's fire system continues to be operable; but the two smoke alarms and the pull station have not been repaired. DES - D said that the delay was related to parts needing to be ordered by the fire protection company. DES - D did provide a quote from the fire protection company that was signed by the facility on 1/30/20. DES - D said that fire protection company was scheduled to make the repairs on 3/5/20. DES - D said that on 3/5/20 the fire protection company called the facility and said that the wrong parts had been sent to them and they would need to re-order the parts. On [DATE] at 3:30 PM, NHA - A was asked about the delay in providing information/documentation showing that the facility's fire alarm system was operable and residents were safe. NHA - A said that the incident had occurred when a former NHA was at the facility. Additionally, RMD - E, had to travel from another city to assist DES - D in obtaining the information.