STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/16/2024, Surveyors completed a standard survey and 3 complaint investigations. As a result, 5 deficient practices were identified. Two complaints were unsubstantiated, and 1 complaint was substantiated. Census: 41	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents (Resident 2, Resident 7, and Resident 13) reviewed received her/his medications in the dosage and at intervals prescribed by the practitioner. Resident 2 missed 18 doses of Novolog insulin between 02/14/2024-02/19/2024 and 3 doses Victoza between 02/20/2024-02/22/2024. Resident 13 missed 36 doses of a risperidone 1 milligram (mg) between 02/03/2024-03/11/2024. Resident 7 missed 9 doses metformin between 02/01/2024-02/05/2024 and 55 doses Brilinta between 12/11/2023-01/07/2024. Findings include:	N 352		

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
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 1 On 10/17/2023, the department received a concern regarding residents not receiving medications. On 03/11/2024, at 1:30 PM, Surveyors reviewed resident's records and identified the following: Example 1 Resident 2 was admitted on 09/11/2020 with diagnosis including diabetes. Resident 2's February 2024 Medication Administration Record (MAR) and physician's orders indicated Resident 2 was prescribed Novolog flex pen, to be administered 12 units at 8:00 AM, 12:00 PM, and 4:00 PM for diabetes and Victoza 0.6 mg injection at 8:00 AM for diabetes. Resident 2's MAR indicated Resident 2 did not receive her/his Novolog flexpen at 8:00 AM, 12:00 PM, or 4:00 PM from 02/14/2024-02/19/2024. Resident 2's MAR stated, "Refused - Med not available on cart." Resident 2 missed 18 doses of Novolog insulin in February 2024. Resident 2's MAR indicated Resident 2 did not receive her/his Victoza injection at 8:00 AM from 02/20/2024-02/22/2024. Resident 2's MAR stated, "Refused - Med not available on cart." Resident 2 missed 3 doses of her/his prescribed medications. Resident 2's MAR reported her/his blood sugar levels during the duration of missed medication for diabetes as follows: 02/14/2024 at 7:53 AM: 92 02/14/2024 at 11:58 AM: 443 02/14/2024 at 5:05 PM: 382	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 2 02/15/2024 at 4:45 PM: 275 02/16/2024 at 8:55 AM: 343 02/16/2024 at 12:05 PM: 445 02/16/2024 at 4:41 PM: 353 02/17/2024 at 3:58 PM: 364 02/18/2024 at 3:06 PM: 406 02/19/2024 at 8:43 AM: 200 02/19/2024 at 11:44 AM: 389 02/19/2024 at 5:16 PM: 343 02/20/2024 at 8:51 AM: 445 02/20/2024 at 11:16 AM: 348 02/20/2024 at 3:31 PM: 341 02/21/2024 at 8:11 AM: 321 02/21/2024 at 11:43 AM: 88 02/21/2024 at 5:22 PM: 357 02/22/2024 at 7:37 AM: 73 02/22/2024 at 12:05 PM: 320 02/22/2024 at 4:26 PM: 212 Example 2 Resident 7 was admitted on 06/12/2023 with diagnoses including type 2 diabetes and hypertension. Resident 7's December 2023, January 2024, and February 2024 MARs and physician's orders indicated Resident 7 was prescribed metformin 500 mg for diabetes at 8:00 AM and 4:00 PM and Brilinta 90 mg for stroke and heart attack prevention at 8:00 AM and 8:00 PM. Resident 7's MAR indicated Resident 7 did not receive her/his 8:00 AM dose of metformin 500 mg from 02/01/2024-02/05/2024 and her/his 4:00 PM dose of metformin 500 mg from 02/04/2024. Resident 7's MAR stated, "Refused - Med not available on cart." Resident 7 missed a total of 7 doses of metformin. Resident 7's MARs indicated Resident 7 did not	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 3 receive her/his 8:00 AM Brilinta 90 mg dose from 12/11/2023-01/07/2024 and her/his 8:00 PM dose from 12/12/2023-01/07/2024. Resident 7's MAR stated, "Refused - Med not available on cart." Resident 7 missed a total of 55 doses of Brilinta. Example 3 Resident 13 was admitted on 11/27/2023 with a diagnosis of Huntington's disease. Resident 13's February 2024 and March 2024 MARs and physician's orders indicated Resident 13 was prescribed risperidone 1 mg twice daily for agitation. Resident 13's MAR indicated Resident 13 did not receive her/his 8:00 AM and 8:00 PM dose of risperidone 1 mg from 02/03/2024-03/11/2024. Resident 13's MAR stated, "Refused - Med not available on cart." Resident 13 missed 72 missed doses of risperidone. On 05/16/2024, at 11:00 AM, Surveyors interviewed Administrator A and Regional Clinical Director (RCD) F. Administrator A and RCD F confirmed Surveyors concerns with medication administration. Administrator A and RCD F reported if a resident misses a medication, they were to report it to Director of Wellness D. Administrator A reported s/he was unsure if the previous Director of Wellness was informed of the concerns with medications not in the cart.	N 352		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to	N 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 401	Continued From page 4 the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were labeled to ensure proper and safe usage in 2 of 2 medication carts. Resident insulin pens and inhalers were found without a pharmacy label. Findings include: On 04/05/2024, at 11:15 AM, Surveyors observed the medication carts. Surveyors observed the following medications located in the medication carts without labels: Memory Care medication cart: Resident 3 - Advair diskus (fluticasone propionate and salmeterol inhalation powder) 250 micrograms (mcg)/50 mcg Assisted Living Medication Cart: Resident 6 - Humalog insulin pen - Lantus insulin pen - Lispro insulin pen - Trelegy ellipta inhaler - Breo ellipta inhaler Resident 7 - Levemir insulin pen	N 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 401	Continued From page 5 Resident 8 - Lispro insulin pen - Lantus insulin pen Resident 9 - Trelegy ellipta inhaler Unknown - Trelegy ellipta inhaler with only a resident's initials - Trelegy ellipta inhaler with no identifiers on the inhaler On 05/16/2024, at 11:00 AM, Surveyors interviewed Administrator A and Regional Clinical Director (RCD) F. RCD F confirmed medications should have contained prescriptive information. RCD F reported the policy was to complete an audit on medications quarterly. RCD F reported Director of Wellness D or designee would have been responsible to complete the audits. RCD F reported s/he and Director of Wellness D completed an audit within the last month. RCD F reported s/he removed the medications without labels and reordered the medication to ensure compliance.	N 401		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or	N 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 406	Continued From page 6 recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. The facility did not establish an effective procedure the handling medications when a resident is discharged from the facility. Expired medications were observed stored with residents' non-expired medications, inside 2 of 2 medication storage areas. Two of 2 residents (Resident 14 and Resident 15) had medications left in the medication cart after they discharged. Findings include: The provider is licensed to care for up to 74 residents in the client groups of terminally ill, physically disabled, irreversible dementia/Alzheimer's and advanced aged. On 03/05/2023, at 9:15 AM, Surveyors toured the facility and observed the following: Resident 4	N 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 406	Continued From page 7	N 406		

- Lorazepam 0.5 mg (milligram) tablet, discard after 08/2023
- Albuterol sulfate HFA (hydrofluoroalkane) inhalation aerosol 90 mcg (microgram) per actuation, discard after 08/2023
- Albuterol sulfate HFA (hydrofluoroalkane) inhalation aerosol 90 mcg (microgram) per actuation, discard after 01/2024

Resident 5
- Acetaminophen-codeine 300-30 mg tablets, discard after 09/2023

Resident 3
- Albuterol sulfate inhalation aerosol 90 mcg, dispensed on 12/12/2022, use before manufacturer labeled date

Unknown:
- Advair diskus (fluticasone propionate and salmeterol inhalation powder) 250 mcg/50 mcg, expiration date 02/2024

Resident 6
- Humalog KwikPen insulin pen, with a handwritten date of 11/13/2023

Resident 10
- 3 Tresiba FlexTouch insulin pen with an expiration date 01/2024

Resident 11
- 5 Lantus insulin pens with an expiration date of 01/2024

Resident 14
- 5 Humalog KwikPens

Resident 15
- 45 vials of ipratropium/albuterol with a discard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 406	Continued From page 8 date of 01/2024 Division of Quality Assurance Insulin Storage Guide publication dated 11/2016 indicated, "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows: ...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...The following tables address specific expiration or beyond-use dating guidelines that apply to insulin products...Pens...Humalog KwikPen: label expiration date 28 days when seal is punctured... ...Lantus Pen: label expiration date 28 days when seal is punctured..." On 03/05/2024, at 2:30 PM, Surveyor reviewed the resident roster. The resident roster identified Resident 14, and Resident 15 were not living at the facility. On 05/16/2024, at 11:00 AM, Surveyors interviewed Administrator A and Regional Clinical Director (RCD) F. RCD F confirmed medications should contain prescriptive information. RCD F reported the policy is to complete an audit on medications quarterly. RCD F reported Director of Wellness D or designee would be responsible to complete the audits. RCD F reported her/him, and Director of Wellness D completed an audit within the last month and identified the concerns of the Surveyors. Administrator A reported the previous Director of Wellness did not complete her/his duties as appropriate.	N 406		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 419	Continued From page 9	N 419		

medicine cabinets locked and the key available only to personnel identified by the CBRF.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 2 of 2 medication rooms were locked at all times. The medication closet on the secured memory care side, was unlocked, and contained resident medications on a shelf. The medication closet on the assisted living side was unlocked. The medication closet contained a refrigerator, which was not locked and contained resident stored medications. This had the potential to affect 41 of 41 residents residing in the facility.

Findings include:

The provider is licensed to care for up to 74 residents in the client groups of terminally ill, physically disabled, irreversible dementia/Alzheimer's and advanced aged.

On 03/05/2023, at 9:15 AM, Surveyor toured the facility and observed the following:

Memory Care side:

The medication closet was unsecured. The doors to the medication closet had a key locking mechanism, which was not engaged. The closet contained shelving, a medication cart, and 2 medication refrigerators. The refrigerators contained locking mechanisms, which were not engaged.

Located in the refrigerator:

Resident 1
- Latanoprost ophthalmic solution 0.005% 125

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 419	Continued From page 10 microgram (mcg)/2.5 milliliter (mL) Resident 2 - Glucagon Emergency Kit 1 mcg vial - Victoza 2-pack 0.6 milligram (mg)/0.1 mL (18 mg/3 mL) - Novolog Flexpen 100 unit/mL insulin pen - Lantus Solostar 100 unit/mL (3 mL) insulin House Account: - Tubersol 5 tuberculin Unit/0.1 mL vial Located on top of shelf in a box: Resident 3 - Aspirin 81 mg tablet (tab) chew - PreserVision AREDS 2 250-200-40-1 milligram (mg) - Amlodipine besylate 5 mg tablet - Docusate sodium 100 mg capsule - Sertraline HCL (hydrochloride) 100 mg tablet - Aspirin 81 mg tab chew - PreserVision AREDS 2 250-200-40-1 mg-u - Furosemide 20 mg tablet - Valsartan 160 mg tablet - Docusate sodium 100 mg capsule - Amlodipine besylate 5 mg tablet - Memantine HCL 10 mg tablet - Glipizide ER (extended release) 5 mg tab ER 24 - Aspirin 81 mg tab chew - PreserVision AREDS 250-200-40-1 mg-u - Valsartan 160 mg tablet - Furosemide 20 mg tablet - Amlodipine besylate 5 mg tablet - Glipizide ER 5 mg tab ER 24 - Memantine HCL 10 mg tablet - Docusate sodium 100 mg capsule - PreserVision AREDS 2 250-200-40-1 mg-u - PreserVision AREDS 2 250-200-40-1 mg-u - PreserVision AREDS 2 250-200-40-1 mg-u	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 419	Continued From page 11 - Olanzapine 5 mg tablet - Memantine HCL 10 mg tablet - Donepezil HCL 10 mg tablet - Docusate sodium 100 mg capsule - Memantine HCL 10 mg tablet - Docusate sodium 100 mg capsule - Donepezil HCL 10 mg tablet - Donepezil HCL 10 mg tablet - Docusate sodium 100 mg capsule - Memantine HCL 10 mg tablet Assisted Living side: Surveyor observed the medication closet. The door to the medication door contained a locking mechanism which was not engaged. Inside the medication closet, there was a refrigerator with resident medications. The unlocked refrigerator contained 57 insulin pens, 9 expired insulin pens, 45 vials of ipratropium albuterol which included the following: Resident 8 - 8 Lantus insulin pens - 3 Lispro insulin pens - 5 Humalog insulin pens Resident 6 - 6 Lantus pens Resident 10 - 5 Novolog insulin pens - 1 expired Novolog insulin pen - 5 Tresiba pens - 3 expired Tresiba pens Resident 7 - 3 Levemir insulin pens Resident 6	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 419	Continued From page 12 - 9 Lispro insulin pens Resident 11 - 4 Lantus insulin pens - 4 Humalog insulin pens - 5 expired Lantus insulin pens Resident 14 - 45 vials of ipratropium/Albuterol Resident 15 - 5 Humalog insulin pens Surveyors observed residents moving freely throughout the facility. On 05/16/2024, at 11:00 AM, Surveyors interviewed Administrator A and Regional Clinical Director (RCD) F. Administrator A and RCD F confirmed the medication cart and closet should have been locked at all times.	N 419		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 452	Continued From page 13	N 452		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure hot food was held at 140° F or above and cold temperatures were held at 40° F or below until serving. Styrofoam containers containing resident meals were kept warm until serving. This had the potential to affect 41 of 41 residents residing in the facility.

Findings include:

On 03/05/2024 at 9:15 AM, Surveyors toured the facility and observed a cart with disposable Styrofoam type to go container. At 9:45 AM, Surveyors observed Caregiver C pushing the cart around to resident rooms delivering the to go containers.

On 03/05/2024, at 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C reported the meals were for the residents who ate their meals in their bedrooms. Caregiver C reported they tried to get the meals delivered right away, but they needed to assist with the meals to the residents in the dining room as well.

On 03/05/2024, at 10:00 AM, Surveyor interviewed Resident 12. Resident 12 reported s/he enjoyed eating her/his breakfast in her/his room. Resident 12 reported the food was good but often cold. Resident 12 stated, "There just isn't enough staff to do it all."

On 03/11/2024, at 10:20 AM, Surveyors interviewed Kitchen Staff E. Kitchen Staff E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018350	A. BUILDING: _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 452	Continued From page 14 reported the caregivers were responsible for delivering the meals to the residents. Kitchen Staff E reported they put the food into the disposable containers and put the cart into the dining room for the caregivers to deliver. Kitchen Staff E reported the caregivers were supposed to deliver the food right away, but they also had to assist the residents in the dining room. When Surveyors inquired if the kitchen staff helped with food delivery, Kitchen Staff E reported there was not enough staff to assist 2 different sides with food delivery and ensure all meals were on time. On 05/16/2024, at 11:00 AM, Surveyors interviewed Administrator A and Regional Clinical Director (RCD) F. Administrator A confirmed the food safety guideline. Administrator A reported staff typically dished up and delivered the room trays after the residents in the dining room had completed breakfast. Administrator A reported s/he would talk with staff.	N 452		