

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Waters Edge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3415 N Sheridan Rd 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on facility policy, record review and interviews, the facility failed to ensure a safe environment for one of nine residents (Resident (R) 1) reviewed for accidents. R1 fell from his bed and onto the floor while a staff member (Certified Nursing Assistant (CNA1) was providing his routine care. This failure caused R1 to experience significant injuries related to the fall, including a broken hip and a large laceration to his forehead requiring nine staples.</p> <p>The findings include:</p> <p>The facility's Accidents and Supervision Policy dated 12/29/22 read, in pertinent part, The resident environment will remain as free of accident hazards as possible; and Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency, b. Based on the individual resident's assessed needs and identified hazards in the resident environment.</p> <p>Review of the facility's incident logs revealed an entry, dated 09/09/24, which indicated R1 had experienced a fall, on that date, that resulted in a head injury to the resident.</p> <p>Review of R1's Admission Record, dated 10/30/24 and found in the Electronic Medical Record (EMR) under the Profile Tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included history of motor vehicle accident (MVA) with traumatic brain injury (TBI).</p> <p>Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/05/22, revealed a Brief Interview for Mental Status (BIMS) assessment could not be completed related to the resident's poor cognition and inability to communicate. The resident was significantly cognitively impaired and minimally responsive. The assessment revealed R1 was totally dependent upon staff to complete all his Activities of Daily Living (ADLs) and required assistance from at least two staff members for bed mobility/to move about in his bed.</p> <p>Review of R1's Impaired Mobility Care Plan, dated 07/18/24 and found in the EMR under the Care Plan Tab, revealed the resident had impaired mobility related to his history of TBI. The care plan indicated the resident was completely dependent upon staff for all transfers and bed mobility with assist of two staff members.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's Fall Risk Evaluation, dated 07/04/24 and found in the EMR under the Evaluations Tab, revealed a fall risk score of 12, which indicated the resident was at moderate risk for falls. The evaluation indicated R1 was always totally incontinent, was disoriented, was confined to a chair, and was unable to independently able to come to a standing position.</p> <p>Review of R1's Functional Ability Evaluation, dated 08/07/24 and found in the EMR under the Evaluations Tab, revealed the resident had range of motion (ROM) impairments to his upper and lower extremities on both side of his body, was dependent upon a wheelchair for mobility, was completely dependent upon staff to complete all of his ADLs, including rolling in bed, bathing, personal hygiene, and transfers in and out of bed.</p> <p>Review of R1's Progress Notes, dated 09/09/24 at 3:41 PM and found in the EMR under the Notes Tab, read, in pertinent part, Called to Room by CNA. Resident laying on floor on back on left side of bed blood on left side of head noted. Had laceration (cut) to left scalp and left ear. Pressure applied to area .no s/sx (signs or symptoms) of pain noted. Family called and wants (R1) sent to ER (emergency room) right away via 911 (emergency). Sent to (local Emergency Department). Transported via rescue.</p> <p>Review of R1's Progress Notes, dated 09/09/24 at 4:00 PM and found in the EMR under the Notes Tab, read, in pertinent part, Situation: Resident had fall from bed while getting cares has laceration to Left head and Left ear.</p> <p>Review of R1's Progress Notes, dated 09/09/24 at 8:25 PM and found in the EMR under the Notes Tab, read, in pertinent part, Returned from ER, all scans normal, 9 staples to left scalp, family aware no questions at this time.</p> <p>Review of R1's IDT (interdisciplinary team) Progress Notes, dated 09/09/24 at 8:25 PM and found in the EMR under the Notes Tab, read, in pertinent part, Late Entry: Note Text: Team met to discuss recent fall. CNA was in room changing resident when resident rolled out of bed on the left side of the bed. Laceration to head and resident was sent out to the hospital for evaluation. Further investigation showed that resident's plan of care was not followed. Care plan reviewed all other appropriate interventions were in place. Updated for resident to have a bari (large) bed. Education also provided to Staff regarding following plan of care.</p> <p>Review of R1's Progress Notes, dated 09/09/24 at 11:15 PM and found in the EMR under the Notes Tab, read, in pertinent part, resident was sent back to ER because family was concerned about high heart rate and O2 (oxygen) at 1730 (5:30 PM). This writer called ER for update and resident was admitted for UTI (urinary tract infection).</p> <p>Review of R1's Progress Notes, dated 09/16/24 at 10:49 PM and found in the EMR under the Notes Tab, read, in pertinent part, Clinical Summary: Resident awake eyes open, non-verbal, does not follow commands, skin warm and dry no s/sx (signs or symptoms) of pain, has 2 surgical incisions to Right hip with bruising noted, Dressing CDI (clean, dry and intact), blister to left foot both feet on pillows, left scalp has 9 staples to laceration, no drainage noted, .Total care, Hoyer (transfer) lift assist of 2 with bed mobility, Right leg swollen from hip to lower extremity, .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's History and Physical, dated 09/17/24, completed by the resident's physician, and found in the EMR under the Notes Tab, revealed, in pertinent part, Chief Complaint: [AGE] year-old male resident at (Facility) was seen for complete history and physical. The Medical problems that were addressed today: *Recent hospital admission: The resident was admitted on [DATE], decreased level of responsiveness/altered mental status post falling (sic) of his bed while getting care, has laceration to Left head and Left ear. in the ED he was found to have cystitis/UTI and was a treated with IV (intravenous) Rocephin (an antibiotic medication) and IV fluids And also was found to have displaced intertrochanteric fracture of the right femur, orthopedic surgery was consulted, he underwent surgery (to repair his broken femur) on September 12, 2024 . *Right femur fracture: S/P (status post) surgery on September 12, 2024.</p> <p>The facility's investigation related to R1's fall from bed, dated 09/16/24 and provided directly to the surveyor, revealed CNA1 did not follow the resident's established plan of care while changing the resident on 09/09/24. The investigation revealed R1 was to be moved about in bed by two staff members and CNA1 provided care to R1, and moved him about in his bed, without assistance of any additional staff. The investigation revealed R1 experienced a laceration to his head and a fractured right hip related to the fall.</p> <p>During an interview with the Administrator and Director of Nursing (DON) on 10/29/24 at 3:00 PM, both confirmed their expectation was staff were to follow each resident's plan of care related to the provision of care. The Administrator confirmed CNA1 did not follow R1's plan of care when providing care on 09/09/24 and this contributed to the resident's fall.</p>