STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to have sufficient nursing staff with the competencies and skills sets to ensure one (Resident (R)7) out of a total sample of 15 residents, had the correct ordered amount of insulin administered. This had the potential for the resident to have a decreased blood glucose level and potential complications. Findings include:Review of R7's undated admission Record located in the electronic medical record (EMR) under the Resident tab revealed she was admitted to the facility on [DATE] with a diagnosis of type II diabetes mellitus. Review of the facility's Incident Report provided by the facility dated 07/26/25 revealed that R7 was inadvertently given 15 units of lispro insulin, instead of four units as prescribed. Licensed Practical Nurse (LPN)1 took R7's blood sugar at 9:35 PM. Her blood sugar was 185. Lantus was held. Responsible party and medical provider were contacted because of significant medication error. Monitoring orders were given. R7 did not display any adverse effects or negative outcomes related to the medication error during the monitoring period. During an interview on 08/20/25 at 10:53 PM, the Administrator revealed, LPN1 was a recent new graduate nurse and in training. It was her second weekend working, and her third shift at the facility. She was being orientated by LPN2. There was a nurse call-off on the unit and LPN2 took the first half assignment and cart covering the call-off and LPN1 took the second half assignment and cart. LPN1 stated she would take the original assignment and a cart on her own with the understanding that another nurse would also be on the floor working to help her. There was no documented evidence of orientation or a skills checkoff prior to LPN1 taking an assignment on her own. The Administrator revealed the facility did not have documented checkoffs. We do verbal trainings, talk about their comfort level on tasks providing nursing care, and let them tell us when they feel ready to take the cart. During an interview on 08/20/25 at 11:50 AM, LPN2 revealed, it was supposed to be LPN1 and I on the floor. I was going to orientate her. There was a nurse call-off and we were short staffed. So, I helped with residents on the hall and told LPN1 to let me know if she has any questions or needs help anytime. I stayed with her as much as I could, but with a nurse call-off, I had to take the front half of the hall and LPN1 took the back half of the hall. We don't have orientation check-off sheets that they have to complete and sign off before taking a cart on their own.During an interview on 08/20/25 at 12:07 PM, LPN1 revealed, she had recently graduated nursing school on 06/14/25. She revealed she was asked upon hire how much orientation she would like and requested six weeks (equal to (12) eight-hour shifts) since this was my first nursing job. I clocked in for my shift on 07/25/25 expecting to be in orientation with LPN2. Orientation was supposed to include a nurse working alongside me the entire shift overseeing all job duties and tasks. I was given an assignment and med cart of my own instead due to the facility being short-staffed that shift. I even requested additional training shifts after my six weeks of training was completed.During a follow up interview on 08/20/25 at 1:20 PM, the Administrator revealed that the facility did not provide official training for nursing. LPN1 went to nursing school and learned all the rights of medication administration and should have followed that. We are going to ensure LPN1 gets her six weeks of orientation/training or more if she feels she needs it. We immediately implemented education and skills check-off to nurses caring for diabetic residents on each shift to demonstrated skills (competency) in Rights of Drug Administration and Insulin. Review of the Primary Nurse Job Description (undated), provided by the facility revealed the primary nurse was to Provide quality nursing care to the residents. and coordinate all aspects of a resident's care with other disciplines in the center.Review of the Facility Assessment with a review dated 08/06/24 and provided by the facility revealed the facility will have nurses' complete competency check-offs upon hire, annually, and as needed (PRN). Review of the facility's policy titled, Nursing Services and Sufficient Staff revised 02/25/25, revealed, Guideline: It is the guideline of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Also indicated under section, Explanation and Compliance Guideless: 4. The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a significant medication error did not occur when the physician's orders were not followed during administration of insulin for one (Resident (R)7) of three sampled residents related to insulin administration out of a total sample of 15 residents. This had the potential for the resident to have an adverse reaction to the incorrect amount of insulin administered. Findings include:Review of R7's undated admission Record located in the electronic medical record (EMR) under the Resident tab revealed she was admitted to the facility on [DATE] with a diagnosis of type II diabetes mellitus. Review of R7's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 06/09/25 and located under the MDS tab of the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero out of 15, which indicated the resident was severely cognitively impaired.Review of R7's physician's Orders dated 07/23/25 located in the EMR under the Resident tab revealed orders for: 1. Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 15 unit subcutaneously at bedtime for diabetes.2. Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale subcutaneously before meals and at bedtime for diabetes if:131 - 150 = 2 units;151 - 200 = 4 units;201 - 250 = 6 units;251 - 300 = 8 units;301 - 350 = 10 units;351 - 400 = 12 units;401 - 450 = 14 units;451 - 500 = 16 units Notify the MD if >451,Review of the facility's Incident Report dated 07/26/25 and provided by the facility revealed that R7 was inadvertently given 15 units of lispro, instead of four units as prescribed. Licensed Practical Nurse (LPN)1 took R7's blood sugar at 9:35 PM. Her blood sugar was 185. Lantus was held. Responsible party and medical provider were contacted because of the significant medication error. Monitoring orders were given. R7 did not display any adverse effects or negative outcomes related to the medication error during the monitoring period.During an interview on 08/20/25 at 10:26 AM, the Medical Director revealed, (R7) blood sugars trended on the higher side. Since the error was made with a short-acting insulin and it peaked within 30 minutes, there really wasn't any real concern. The facility acted appropriately and we were notified immediately.During an interview on 08/20/25 at 12:07 PM, LPN1 revealed, I should have noticed that I gave the wrong amount of insulin. As soon as I went back to my cart, I knew immediately what I had done. I told LPN2 right away and we told the night supervisor. She made the calls to the family, physician, Director of Nursing (DON), and Administrator. Then we monitored R7 for adverse effects for the next 48 hours.During an interview on 08/20/25 at 1:20 PM, the Administrator revealed he was notified immediately when the insulin error occurred. We kept the provider updated throughout the monitoring period. R7 did not have any adverse effects, and the blood sugar never went below the 185 reading and even went as high as the low 300's. Review of the facility Medication Error Counseling document provided by the facility completed by LPN1 and the DON revealed, Action Items: 1. Ensure Risk Management Report completed in its entirety. 2. Provide education based on investigation and root cause analysis (RCA) results (attach evidence of education). 3. Complete Medication Pass Competency prior to next scheduled shift (if pertinent). 4. Schedule subsequent Medication Pass Audits (determine through QA frequency and duration) 5. Complete Quality Assurance Performance Improvement Program (QAPI) Documentation of Plan and hold Ad Hoc QAPI (when high-risk medication involved and / or negative or potential negative outcome occurs) to be completed with LPN1 and the facility. Documentation of education and medication pass competencies completed by all nurses was reviewed.