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	09/30/2025

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not provide a safe, clean, comfortable, and homelike environment. This had the potential to affect all 103 Residents residing in the facility at the time of the survey.*) R13 informed Surveyor that R13's room does not get cleaned daily and that the garbage is not always emptied causing odors in the bedroom.*) R107 informed Surveyor that R107's room does not get cleaned every day per policy and that the garbage do not get emptied. R107 had a dry yellow spot on the top sheet of R107's bed and a urine odor was noted and R107's garbage was full.*) Surveyor reviewed grievances from May 2025 - August 2025 and noted 11 total grievances regarding bedrooms not being cleaned.Findings include:The facility housekeeping and laundry services are outsourced and provided by [laundry/housekeeping service company]. The facility provided Surveyor a Housekeeping and Laundry Program sheet that documents: . Areas of responsibility- Cleaning of all resident areas, common areas, administrative and ancillary offices, nursing areas, employee occupied areas, entrances.*) R13 was admitted to the facility on [DATE]. R13's admission Minimum Data Set (MDS) assessment dated [DATE] documents R13 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R13 has intact cognition.On 9/2/2025, at 9:30AM, Surveyor interviewed R13 who stated R13's bedroom does not get cleaned daily. Surveyor asked when the last time R13's bedroom was cleaned. R13 stated that could not remember, maybe Saturday. R13 stated there was only 1 cleaning person that actually used sprays to clean R13's bedroom but R13 has not seen them for a while. Surveyor asked how housekeeping cleans R13's room now. R13 stated that they just empty the garbage's when they are full and will wipe up room and mop about 1 time a week. Surveyor noted a slight urine odor in R13's room. R13 stated the aide was going to come and change R13's sheets and get R13 ready for the day. Surveyor asked of R13 has reported that R13's room is not being cleaned. R13 stated R13 usually notifies someone, and they send someone in to clean R13's room. *) R107 was admitted to the facility on [DATE]. R107's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R107 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R107 has intact cognition.On 9/2/2025, at 11:18AM, Surveyor interviewed R107 who stated R107's room does not get cleaned daily. Surveyor asked when the last time R107's room got cleaned. R107 replied it was cleaned on Friday or Saturday. R107 has filled out grievances and the facility will send someone in to clean R107's room. R107 stated housekeeping used to have to fill out a sheet when the room clean was completed, but R107 has not seen that happen for a while.Surveyor noted a dried yellow area on the top sheet of R107's bed and R107's garbage was full.On 9/2/2025, at 11:23AM, Surveyor interviewed licensed practical nurse (LPN, agency)-Y and certified nursing assistant (CNA)-Z who stated housekeeping does not always clean resident rooms daily and nursing staff has to clean up messes at times. LPN-Y stated that housekeeping has not been on the unit yet today that LPN-Y could tell. CNA-Z stated that the cleanliness of the facility could be better and that some days residents' rooms do not get cleaned. CNA-Z stated that it has been reported but not sure what has happened.*) On 9/2/2025, Surveyor reviewed the grievances from May 2025 - August 2025 and noted 11 grievances filed regarding cleanliness during that time. The grievances referenced resident room not being cleaned. The investigation concluded that the resident's rooms were not cleaned and the resolution notes on the grievances documented sending housekeeping in to clean the resident's rooms. Surveyor noted that an investigation documented no resident rooms were cleaned on the 2-south unit on 5/24/2025 - 5/26/2025. On 9/26/2025, at 11:30AM, Surveyor interviewed housekeeper-AA who stated that there should be 1 housekeeper on each unit and residents' room should get cleaned daily, but that does not always happen. Housekeeper-AA was not sure why some resident's rooms do not get cleaned, just that at times housekeeper-AA is asked to clean a resident's room on a different unit than the one assigned. Surveyor asked what gets cleaned daily. Housekeeper-AA replied that the resident's garbage is emptied, sweep the room, wipe down surfaces, and get bedrooms ready for new admissions. Housekeeper-AA stated that resident rooms get a deep clean monthly. Housekeeper stated that if there is anything on the ground such as a body fluid that is more than a quarter cup in size, housekeeping will not clean it up and that it is the facility staff responsibility to clean which facility staff can not always get to it right away if they are busy.On 9/2/2025 at 11:49AM, Surveyor interviewed district manager-BB who stated housekeeping should clean rooms daily that includes disinfecting surfaces, sweeping, mopping, and cleaning bathrooms. District manager-BB stated that resident get basic cleaning daily and will get a deep clean monthly that includes

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from verbal, physical, and sexual abuse between residents residing on the facility's dementia unit. This deficient practice had the potential to affect all 30 residents residing on the facility's dementia unit.12 different allegations/incident of resident to resident abuse were identified during the survey. Facility records indicate R89 has a history of inappropriate sexual behavior. Additionally, a care plan indicated R89 has behavior problems of yelling, grabbing, displaying loving affection towards females, refusing cares, and combative. The facility had an awareness of R89's likelihood to engage in sexually inappropriate behavior and did not take steps to prevent it from occurring. Despite this known history, supervision for R89 was only increased at time of incidents but then was not continued to prevent further incidents: *On 4/19/25, an allegation of resident-to-resident altercation involving R89 and R122 was reported immediately to Nursing Home Administrator (NHA)-A. *On 6/4/25, R89 was observed in R110's room (a female resident with a history of sexual assault) touching her inappropriately. R89 was on R89's knees at R110's bedside. R110's brief was off and was not covered with a sheet or blanket. R89 was observed with R89's hand on R110's vaginal area *On 8/10/25, R89 was observed to have R89's hand under R110's shirt. *On 4/19/25, R89 was observed punching R122 in the face in which R122 sustained a skin tear to the left cheek. *On 6/28/25, R89 was observed verbally abusing and physically threatening R39. *On 9/8/25 R89 was found sitting on R110's bed at 3:43 PM. R89 was on 1:1 supervision on day and PM shifts and should not have had access to R110's room. This is the third encounter between R89 and R110. Surveyor's investigation demonstrates the facility was aware of R89's history of touching R110 in the past that was not addressed based on staff interviews. Staff reported R106 is known to have physical aggression towards R121 and staff reported escalating behaviors of R106 towards R121. The facility did not ensure R121 was free from verbal and physical abuse by R106 residing in the facility. *On 3/17/25, R106 was observed repeatedly hitting R121 with a pillow. *On 4/30/25, R106 was heard to physically threaten R121 by stating R106 wanted to cause bodily harm and cause bleeding. *On 9/22/25 R105 grabbed R46's arm and slapped R46's arm in the dining room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*On 9/23/25 R11 grabbed R77's arm, R77 moved and R11 grabbed R77's arm harder. *On 9/24/25 R89 threw an object that hit R11 in the forehead. *On 9/25/25 R11 grabbed R46's arm and attempted to bite R46. *On 8/30/25, R64 and R46 were involved in an unwitnessed physical altercation which resulted in R64 receiving a red mark and 2 small cuts to the right side of her face. The facility's immediate intervention was to separate both R64 and R46 and place R64 on one-to one-monitoring. The facility failed to keep R64 safe by providing dedicated staff to perform the one-to-one monitoring. The facility did not update R64's plan of care or instruct the staff how to maintain one- to one supervision. On 9/5/25, R64 and R46 were in the dining room without staff providing one-to-one monitoring and again got into a physical altercation. R64 was struck by R46 leaving her with a small scratch to the right side of her face, her left cheek was red, and left eye was slightly swollen. The facility's failure prevent abuse created a finding of immediate jeopardy that began on 3/17/25. On 9/2/25, at 4:28 PM, Nursing Home Administrator (NHA)-A, and Director of Nursing (DON)-B were informed of the Immediate Jeopardy. The Immediate Jeopardy was removed on 9/30/25. The deficient practice continues at a scope and severity (S/S) of a E (potential for harm/pattern) as the facility continues to implement their action plan. Findings Include: The facility's Abuse, Neglect and Exploitation policy and procedure last reviewed/revised 7/12/25 documents: …”Guideline: It is the guideline of this facility to provide protections for the health, welfare and rights of each Resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility has zero tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property.”… …”Definitions: “Abuse” means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	“Alleged Violation” is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. “Physical Abuse” includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. “Sexual Abuse” is non-consensual sexual contact of any type with a resident. “Verbal Abuse” means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.”… ** R89 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Unspecified Severity with Agitation (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Depression (mood disorder that causes persistent feelings of sadness and loss of interest), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Visual Hallucinations(sensory experiences where a person sees objects, people, or scenes that are not actually present. R89 currently has a legal guardian. R89's Quarterly Minimum Data Set (MDS) completed 5/19/25 documents R89's Brief Interview for Mental Status (BIMS) score to be 0 indicating R89 demonstrates severely impaired skills for daily decision making. R89's MDS documents R89's Patient Health Questionnaire (PHQ-9) score to be 0. R89's R89's MDS also documents R89 has no range of motion (ROM) impairment. R89 has experienced trauma due to (this is blank) Triggers that have potential to re-traumatize me (Provide Examples) Sound, smell, touch, taste, sight, other. (this is blank) Once I experience a trigger, I may display these signs/symptoms: anxiety/edginess, overwhelming, anger/irritability, changes in mood state, nightmares, change in sleep pattern, confusion/disorientation, pain/achiness, muscle tension, extreme alertness/hypervigilance, withdrawal/avoidance of activities, other Initiated 2/24/25 Revised 5/14/25 R89 is at risk for mood impairment due to depression and anxiety Initiated 2/13/25 --Monitor/document/report as needed any risk for harm to self: suicidal plan, past attempt at suicide, risky actions, intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Initiated 2/13/25 --Monitor/record/report to MD as needed mood patterns signs of symptoms depression, anxiety, sad mood as per facility behavior monitoring protocols. Initiated 2/13/25 R89 has behavior problems refusing cares, combative, yelling, grabbing, and displaying loving affection towards females. R89 hallucinates. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Initiated 2/13/25 Revised 7/11/25 --Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated 2/13/25 --If reasonable, discuss R89's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to R89. Initiated 2/13/25 --Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Initiated 2/24/25 --Praise any indication of R89's progress/improvement in behavior. Initiated 2/24/25 --Remind R89 that R89's niece wants R89 to work with staff. Initiated 2/24/25 --Explain all procedures to R89 before starting and allow R89 extra time to adjust to changes. Initiated 4/15/25 --Offer a quiet setting. Initiated 4/15/25 --Caregivers to provided opportunity for positive interaction, attention. Stop and talk with R89 as passing by. Initiated 4/15/25 --Provide support to room. Initiated 4/15/25 --Re-approach R89 when initially unapproachable. Initiated 4/15/25 --Allow R89 time to be more independent with cares. Initiated 5/7/25 --Offer coffee per R89's preference to help assist with cares. Initiated 5/14/25 --Offer R89 a shower once a day. R89 is calmer after receiving shower. Initiated 7/11/25 --Monitor for hallucinations. Initiated 7/11/25 --R89 enjoys watching funny animal videos. Initiated 7/17/25 --When becoming agitated offer to take R89 outside. Initiated 7/21/25 --R89 to be 1:1 when out of room. Initiated 8/3/25 R89's Trauma Informed Care completed 6/4/25 documents R89 has experienced physical assault. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1.) On 6/24/25 there was an allegation of abuse between R89 and R110. R110 has diagnoses that include Metabolic Encephalopathy (brain dysfunction resulting from underlying condition that disrupts the metabolic processes), Bipolar(episodes of mood swings ranging from depressive lows to manic highs), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities),. R110's Quarterly Minimum Data Set (MDS) completed 7/25/25 documents R110 demonstrates severely impaired skills for daily decision making with recent and remote memory loss *On 6/4/25, Anon-Q reported that R89 was observed in R110's room. R110 was in a low bed to the ground, without a brief on, and no sheet or blanket covering R110. R89 was observed kneeling on R89's knees next to R110's bed with R89's hand on R110's vaginal area. Anon-Q wrote out a written statement. Human Resources (HR)-L also provided a written statement as HR-L had been walking with Anon-Q at the time. On 8/25/25, at 2:30 PM, Surveyor interviewed Anon-Q. Anon-Q informed Surveyor that Anon-Q observed R89 touching R110 on R110's vagina area. Anon-Q described that R89 was out of R89's wheelchair on R89's knees next to R110's bed which was in the lowest position. R89's hand was on R110's vaginal area. R110's brief was off and R110 was uncovered with no sheet or blanket. Anon-Q stated Anon-Q had to physically lift R89 up and position R89 back in R89's wheelchair and removed R89 from R110's room. Anon-Q immediately informed Unit Manager (UM)-F. Anon-Q stated that R89 and R110 would often be together and R89 would go into R110's room. Anon-Q stated that R89 has always been “touchy feely” with R110. Anon-Q stated staff were always trying to separate R89 and R110. Anon-Q wrote a statement of what Anon-Q observed and was told by administration to “keep an eye on him”. Anon-Q was informed NHA-A had to look at “tapes”. Staff was informed that R89 was only in R110's room for 30 seconds so nothing could have happened. On 8/26/25, at 8:07 AM, Human Resources (HR)-L informed that HR-L submitted a written statement. HR-L did observe R89 in R110's room, but HR-L stated that HR-L did not see R89 touching R110. HR-L did observe that R110 was not wearing a brief and heard Anon-Q ask R110 if R110 was ok. On 8/26/25, at 9:00 AM, NHA-A informed Surveyor that both the “CNA and HR” had said R89 never touched R110. NHA-A stated that NHA-A watched cameras and that it “was less than 10 seconds” that R89 was in R110's room. NHA-A stated that both R110 and R89 were interviewed about the incident and both R110 and R89 denied. Surveyor questioned how R110 and R89 with severely impaired skills could understand the questions being asked. NHA-A stated it was okay because they were interviewed right after and would have given valid answers despite their severely impaired cognitive skills, memory impairment documented in both R110 and R89's electronic medical record (EMR). On 8/26/25, at 10:06 AM, Anon-Q again provided the exact same details of the sexual assault between R89 and R110 as in previous interview. Anon-Q confirmed that R89 was touching R110's vaginal area. Anon-Q confirmed putting a statement in writing. On 8/26/25, at 10:19 AM, Surveyor was provided a copy of Anon-Q's written statement by Anon-P via email. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/25/25, at 3:44 PM, NHA-A informed Surveyor that the camera tapes from 6/10/25 have been taped over. NHA-A stated that the camera footage only goes back to 7/18/25. NHA-A informed Surveyor that R89 was not in R110's room long enough for anything to happen. On 8/25/25, at 10:54 AM, Surveyor asked Anonymous (Anon)-N about the allegation of R89 between R89 and R110 on 6/4/25. Anon-N stated, “that's an interesting question because it was not on the 24-hour board”. The 24-hour board is the nurse's communication between nurses. Anon-N is aware that a ‘sexual assessment' was completed on every female resident on the unit. Anon-N also informed Surveyor that R89 had an incident of being sexually inappropriate the day before 6/4/25. Anon-N stated that R89 was known to wander in other resident rooms. Anon-N describes R89 as confused, agitated, and not easy to redirect. Anon-N states that R89 gets triggered very easily. On 8/25/25, at 1:01 PM Anonymous 4 (Anon)-P informed Surveyor that Anon-P was aware of the allegation of sexual abuse between R89 and R110. Anon-P stated that NHA-A stated it never happened. Anon-P informed Surveyor that R110 frequently takes off R110's brief and prefers to have R110's brief off and pull legs up into chest almost like in the ‘fetal position'. Anon-P also stated it was common for R89 to wander in and out of rooms and was attracted to R110.Anon-P stated that R110 would frequently take off R110's brief and be in bed naked from the waist down. Anon-P stated administration knew that R89 was obsessed and attracted to R110. Anon-P informed Surveyor that it was a common thing for R110 to take R110's briefs off and go up into the fetal position, with R110's legs open so it could have easily happened with R89 touching R110 in the amount of time administration is stating R89 was in the room. On 8/26/25, at 8:10 AM, Anonymous 6 (Anon)-R informed Surveyor that R89 can be very much sexually inappropriate and is sexually aggressive with words. Anon-R was informed to keep an eye on R89. Anon-R stated that R89 has had multiple resident-to-resident altercations. Anon-R stated that Anon-R stays clear of R89 because R89 punched Anon-R in the mouth causing injury. On 8/26/25, at 12:37 PM, Surveyor interviewed Anonymous (Anon)-G. Anon-G stated that R89 is “touchy feely” with R110. R89 will grab R110's shoulders and rub R110's shoulders. Anon-G has seen R89 kiss R110. R89 would initiate the kissing and R110 would kiss back. Anon-G observed R89 hugging and kissing R110. A couple of months ago Anon-G observed R89 kissing R110 in R110's room. After the 6/10/25 incident between R89 and R110, staff were informed to keep R89 and R110 separated. Anon-G stated that R89 can be disruptive and is supposed to have supervision but does not always have the supervision. On 8/26/25, at 2:01 PM, Surveyor interviewed Unit Manager (UM)-F. UM-F is aware of an incident at the end of June where R89 and R110 were kissing each other. UM-F is aware of R89 going into R110's room. UM-F is aware of R89 going into R110's room. UM-F stated that when R110 is unclothed, R110's door should be shut and the stop sign put across the doorway. On 8/26/25, at 2:38 PM, Director of Nursing (DON)-B informed Surveyor that there was “not enough time for anything to happen”. DON-B then stated that NHA-A “was a big part of the investigation”. DON-B informed Surveyor that R89 was only in the room for 9 seconds so there was not enough time to do anything. On 8/27/25, at 7:10 AM, Anonymous (Anon)-V described R89 has unpredictable and will switch very quickly. Anon-V stated that R89 can be aggressive a lot. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2.) On 8/10/25, Anonymous 11 (Anon)-W documented in R89's electronic medical record (EMR): …”Writer was notified by CNA that R89 tried to put his hand under R110's shirt. When R89 was redirected, R89 became very agitated. Writer notified DON and supervisor. Per DON to start 1:1 with R89 and monitor behaviors.”… On 8/27/25, at 3:51 PM, NHA-A informed Surveyor that there was camera footage, and it never happened, but there is a soft file that NHA-A will provide On 8/28/25, at 8:25 AM, Surveyor observed the camera footage. At 1.04.24, Surveyor observed R110 in R110's wheelchair with R110's legs up in the air, in the hallway next to the handrail. At 1.04.31, R89 comes up from behind, and at 1.04.43, pulls R110's wheelchair closer to R89. At 1.04.54, R89 grabs R110's hands with left hand and right hand goes to bottom of R110's shirt. An unknown resident approaches both R110 and R89 and stands in front of both R110 and R89 and a clear view is obstructed. At 1.05.28, R110 pulls arms and hands away from R89. At 1.05.36, R89 grabs R110's hands again and places R89's hands with R110's hands close to or on R110's chest. At 1.05.53, Anonymous (Anon)-HH is observed coming behind R110 and pulled R110 backward towards the dining room. R89 is observed following R110. On 8/28/25, at 9:18 AM, Surveyor left message for Anon-HH and did not receive a call back during the survey process. On 8/28/25, at 9:27 AM, Surveyor spoke with Anon-W. Anon-W stated it was Anon-W's first time working the unit. Anon-W stated a CNA reported to Anon-W that R89 was attempting to put R89's hand under R110's shirt. Anon-W reported to administration right away and was instructed to place R89 on 1:1 supervision right away and keep R89 and R110 separated. Surveyor reviewed the facility's provided soft file statements. Anon-W's statement states that Anon-HH reported R89 touching R110 inappropriately. The statement obtained by the facility does not specify what the inappropriate touching was. Anon-HH's facility statement also does not refer to what the inappropriate touching was. The typed facility staff statements are not signed by the employee or administration. On 9/2/25, at 12:16 PM, Surveyor interviewed NHA-A in regard to R89 and R110's allegation of sexual abuse. NHA-A stated that R89 was in R110's room for “seconds.” NHA-A stated, because R89 was only in the room for seconds, nothing could have happened. NHA-A states “CNA saw R89 still in R89's chair”, and then stated “R89 was observed trying to climb out of the chair”. Surveyor spoke with NHA-A about the 8/10/25 incident between R89 and R110 and the allegation of inappropriate touching. NHA-A stated that the call went to DON-B and that R89 and R110 were only holding hands which the families are okay with. NHA-A stated that staff “thought something could happen but never saw anything.” 3.) R122 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's (progressive disease that destroys memory and other important mental functions), and Unspecified Dementia, Severe, with Agitation (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life),. R122 had an activated Health Care Power of Attorney (HCPOA) while at the facility. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R122's admission MDS documents R122 has recent/remote memory loss and demonstrates severely impaired skills for daily decision making. R122's MDS documents R122 has continuous inattention. *On 4/19/25, an allegation of resident-to-resident altercation between R89 and R122 was reported immediately to NHA-A. It was reported that R89 had punched R122 in the face causing a skin tear to the left cheek. On 8/25/25, at 1:01 PM, Surveyor interviewed Anonymous (Anon)-P in regard to the incident between R89 and R122. Anon-P stated that R89 thought R122 had called R89 a clown. R89 swung out and Anon-P heard R122 say “ouch”. Anon-P observed a small cut on the outside of R122's left cheek. It was reported that NHA-A stated that NHA-A watched cameras, and it never happened and that R122 bit the inside of R122's lip. Anon-P stated R122 had a fresh injury on the outside of R122's left cheek. Surveyor reviewed R122's EMR and notes that R122 has a completed initial wound assessment dated [DATE] that documents R122 has a new skin tear to the face, however, no other details are documented. On 8/26/25, at 10:42 AM, Surveyor interviewed Anonymous (Anon)-S in regard to the incident between R89 and R122. Anon-S stated that Anon-S was present the night R89 punched R122. Anon-S heard the punch. Anon-S was at the nurse's station and R89 and R122 were in front of the nurse's station. Anon-S back was turned at the time, but Anon-S heard the punch. Anon-S observed R89 have a stance like R89 had just hit R122 and R122 was holding R122's lip. Anon-S reported it immediately to NHA-A. Anon-S was then informed by NHA-A that NHA-A had watched the cameras and R122 had hit R122's self. Anon-S stated that R122's cheek had to be cleaned and treated. Anon-S stated that R89 is physically aggressive with other residents. On 8/27/25, at 4:17 PM, Surveyor interviewed Anonymous (Anon)-T. Anon-T stated that Anon-T was at the nurse's station at the time of the incident between R89 and R122. Anon-T observed R89 punch R122 around the lip area. Anon-T stated that there was definite contact between R89 and R122. Anon-T saw R89 hit R122, and Anon-T stated that Anon-T had to get between R89 and R122 and separate R89 and R122. Anon-T stated R89 is combative and wanders up and down the hallway. Anon-T stated that R89 has punched multiple staff in the face. Anon-T described R89 as having violent tendencies, very unpredictable, would get very angry and quickly switch moods. On 8/27/25, at 3:51 PM, Surveyor interviewed NHA-A about the incident between R89 and R122. NHA-A stated that R122 bit the inside of R122's cheek and nothing happened because the CNA stated R89 and R122 never connected. NHA-A confirmed there is no facility soft file with staff statements of the incident between R89 and R122. NHA-A shared that R89 is quick to temper and impulsive. NHA-A stated R89's Seroquel has been increased and R89 is more stable now. 4.) R39 was admitted to the facility on [DATE] with diagnoses that include Unspecified Dementia, Unspecified Severity, with Anxiety (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R39's admission MDS documents R39 has a Brief Interview for Mental Status (BIMS) score of 4 indicating R39 demonstrates severely impaired skills for daily decision making. R39 has no mood issues. R39's MDS also documents physical behaviors and other behaviors 1-3 days. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*On 6/28/25, an allegation of verbal abuse and physical threatening involving R89 and R39 was reported. On 6/28/25, Anonymous (Anon)-T documented in R89's EMR: …”so R89 began verbally harassing R39 as well, calling R39 expletives and threatening to physically assault R39. “… On 8/26/25, at 2:51 PM, Surveyor interviewed Anon-T regarding R89 threatening R39. Anon-T stated, “it was textbook definition. Harm without injury”. Anon-T stated that R89 became enraged. Anon-T stated R89 was yelling and swearing at R39 and threatened to physically assault R39. Anon-T stated the AM Certified Nursing Assistants (CNAs) had to calm R89 down. Anon-T confirmed to Surveyor that R89 was verbally abusive towards R39 and confirmed R89 threatened to physically assault R39. On 7/1/25, Director of Nursing (DON)-B documented: …”Summary of investigation provides enough information to show nurse charted what she perceived not what actually happened and no threatening remarks were actually made.”… On 9/2/25, at 1:26 PM, Surveyor interviewed DON-B in regard to the incident between R89 and R39. DON-B stated that Anon-T just assumed what was said or done. DON-B stated that DON-B quickly read the documentation and spoke with Anon-T. On 8/28/25, at 2:51 PM, Anonymous 12 (Anon-X) stated that R89 almost came to blows with another resident back in March. Anon-X notified DON-B who informed Anon-X, “if something happens, call the police.” Anon-X described R89 as “straight up violent.” Anon-X stated R89 hit a CNA so hard, the CNA had to go to the hospital. Anon-X also stated that R89 would be sexually inappropriate with staff. Surveyor reviewed the facility's soft file of typed staff statements provided about the incident between R89 and R39. The typed facility staff statements are not signed by the employees. Anon-T's statement does not match what Anon-T confirmed in an interview with Surveyor. 5.) R106 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia and Hemiparesis Following Cerebral Infarction(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Metabolic Encephalopathy (brain dysfunction resulting from underlying condition that disrupts the metabolic processes), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Delusional Disorder (delusions are a specific symptom of psychosis related to thought disorder or mood disorder), and Visual Hallucinations(sensory experiences where a person sees objects, people, or scenes that are not actually present). R106 has a legal guardian. R106's Quarterly MDS completed 7/23/25 documents R106's BIMS score is 12, indicating R106 demonstrates moderately impaired skills for daily decision making. R106's PHQ-9 score is 10, indicating R106 has moderate depressive symptoms. R106's MDS documents hallucinations and delusions. R106's MDS document verbal and physical behaviors, and rejection of care 1-3 days. (continued on next page)

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	09/30/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*On 3/17/25 an allegation of resident-to-resident altercation of R106 hitting R121 with a pillow was immediately reported to NHA-A. R121's EMR documents that nursing staff were monitoring R121 for a resident-to-resident altercation. R121 has diagnoses that include Hemiplegia and Hemiparesis Following Cerebral Infarction (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke) and Vascular Dementia (brain damage caused by multiple strokes). R121 has a legal guardian. R121‘s Quarterly MDS documents R121 has short and long term memory impairment and demonstrates moderately impaired skills for daily decision making. R106's EMR documents that R106 had a room change and being monitored post resident to resident altercation. …”R106 did not make contact with R121 that the altercation took place with. ”… On 8/25/25, at 1:01 PM, Surveyor interviewed Anon-P in regard to the resident-to-resident altercation between R106 and R121. Anon-P stated R106 attacked R121 with a pillow and staff had to physically get between R106 and R121. Anon-P stated staff couldn't leave the room so Anon-P texted NHA-A. NHA-A sent 3 staff up to help. Staff knew something was going to happen. R106 had been unhappy and wanted to move out of the room for a long time. R121 would cough a lot and not cover R121's mouth. R106 had been threatening R121. R106 had thrown juice at R121 prior to the altercation and Anon-P stated NHA-A had been told to get R106 out of R121's room. On 8/26/25, at 9:52 AM, Surveyor interviewed Anon-P again. Anon-P stated that Anon-P and another staff member heard yelling so both went running. Anonymous (Anon)-U made it to the room first and witnessed R106 hitting R121 with the pillow. R121 had indicated R106 had hit R121 over and over with pillow by moving hand back and forth and stating “Bam Bam.” R121's hair was everywhere, and face was red. DON-B came up then and asked questions. On 8/26/25, at 10:22 AM, Surveyor interviewed R106 in regard to the incident. R106 stated that R121 wouldn't cover R121's mouth and was coughing all the time and spreading germs. R106 was afraid of getting sick. R106 stated R106 asked the social worker several times to move out of the room but it never happened. R106 stated R106 was so frustrated. “It got to the point where I couldn't handle it anymore. It had been building up. It was all me, not him. I was hitting him with the pillow. It just reached a point where I couldn't take it anymore. I was so frustrated.” On 8/26/25, at 3:21 PM, Surveyor interviewed Anonymous (Anon)-U. Anon-U stated that Anon-U responded to R106 and R121's room after hearing yelling. Anon-U got into the room and observed R106 repeatedly hitting R121 with a pillow. Anon-U stated that R121's glasses were crooked on R121's face and R121's was red. Anon-U stated R121 was facing the window and R106 was hitting R121 over the head with the pillow. R121 has one arm that is contracted so R121 could not stop R106. Anon-U and Anon-P could not get R121 out of the room to safety because R106 wouldn't let them out of the room. Anon-P texted for help. The rehabilitation director who is no longer employed with the facility was able to get R121 out of the room to safety. Anon-U stated that R106 was accusing R121 of taking things and informed Anon-U and Anon-P that R106 kept telling the facility R106 wanted out and was fed up. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/28/25, at 10:25 AM, Surveyor was walking down the hallway, and R106 asked to speak to Surveyor. R106 stated R106 wanted to explain what happened with R121. R106 stated that “they wouldn't listen to me and move me out of the room. I feel like they tricked me into moving onto the unit. Got to the point with too much frustration. I thought about the pillow and started hitting him with it. I lost it. I didn't want to beat up an old man, but I had enough.” Surveyor asked R106 why R106 barricades R106's door. R106 stated it is to stop R89 from wandering in R106's room and taking R106's belongings. R106 stated if R106 catches R89 in R106's room R106 “feels like killing R89” so barricading the door R106 can hear the chair move when sleeping and then knows when someone is coming into R106's room. On 9/2/25, at 9:11 AM, Unit Manager (UM)-F is unaware of any roommate problems between R106 and R121. On 8/26/25, at 9:00 AM, NHA-A informed Surveyor that R

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	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not report allegations of abuse to the State Survey Agency. Residents (R110, R89, R26, R106, R121, R122, R39, R69, and R116) were identified in 8 allegations of abuse and/or resident-to-resident altercations. Although reported to NHA-A (Nursing Home Administrator), the incidents were not reported immediately to the State Survey Agency. Findings Include: The facility's Abuse, Neglect and Exploitation policy and procedure last reviewed/revised 7/12/25 documents: .Definitions: 'Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 'Alleged Violation' is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. 'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. 'Sexual Abuse' is non-consensual sexual contact of any type with a resident. 'Verbal Abuse' means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.”… .Reporting/Response 1.Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies(e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury. 1) On 3/17/25, an allegation of resident-to-resident altercation involving R106 and R121 was reported immediately to NHA-A. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours. Staff reported they went running to R106 and R121's room because they heard yelling. Staff reported to NHA-A immediately that they had witnessed R106 repeatedly hitting R121 on the head with a pillow. Staff observed R121's glasses on crooked, hair messed up, and redness to the face. Staff separated R106 and R121, but needed assistance to remove R121 from the room as R106 would not allow them to leave. Staff texted NHA-A the circumstances and staff responded to assist. NHA-A informed Surveyor there was no resident-to-resident altercation so no report was made. The facility had a soft file (informal notes). Surveyor's review of the file found typed up staff statements. There were no signatures on the statements. 2) On 4/30/25, an allegation of verbal abuse and physical threatening involving R106 and R121 was reported immediately to NHA-A and was not reported to the State Survey Agency within 24 hours. R106 was overheard by staff saying R106 would “wet someone,” which is slang for causing enough injury to make someone bleed. R121 was in the vicinity when R106 stated this. The nurse on the unit was informed by staff who charted the incident and was informed by the supervisor to keep R106 and R121 separated and continue to monitor R106 and R121 and place R106 and R121 on the 24-hour board. NHA-A informed Surveyor there was no resident-to-resident altercation involving verbal abuse or physically threatening so no report was made. The facility had a soft file of typed unsigned statements from staff. 3) On 4/19/25, an allegation of resident-to-resident altercation involving R89 and R122 was reported immediately to NHA-A. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours. R89 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Unspecified Severity with Agitation(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), Visual Hallucinations(sensory experiences where a person sees objects, people, or scenes that are not actually present), and Essential Hypertension(chronic condition of persistently high blood pressure). R89 currently has a legal guardian. R89 was observed by staff to punch R122 in the face causing a skin tear to the left cheek. The staff member had to get between R89 and R122 to separate R89 and R122. Another staff member heard the physical contact R89 made to R122 with R122 stating “ouch.” NHA-A was immediately notified. NHA-A informed staff that NHA-A watched the cameras and determined there was no resident-to-resident altercation and stated R122 had hit R122's self and bit the inside of R122's cheek. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NHA-A stated the resident-to-resident altercation did not happen as staff reported to surveyor. NHA-A told surveyor there was no soft file on this incident. 4) On 6/4/25, an allegation of sexual abuse involving R89 and R110 was reported immediately to NHA-A. The allegation of sexual abuse was not reported to the State Survey Agency within 2 hours and law enforcement was not notified. Staff reported immediately to NHA-A that R89 had been found in R110's room on R89's knees at R110's bedside. R110's bed was in the lowest position. R110's brief was off and was not covered with a sheet or blanket. R89's hand was on R110's vagina area. NHA-A stated the inappropriate sexual behavior could not have happened as NHA-A watched cameras and R89 was not in the room long enough for anything to happen. The facility had a soft file of typed unsigned statements from staff. 5) On 6/28/25, an allegation of verbal abuse and physical threatening involving R89 and R39 was not reported immediately to NHA-A and was not reported to the State Survey Agency within 24 hours. Staff documented in R89's electronic medical record(EMR) that R89 was verbally assaultive towards R39 and was physically threatening R39. Staff did not report it to NHA-A. Director of Nursing (DON)-B documented in R89's record that staff had documented what was perceived rather than what actually happened. The facility had a soft file of typed unsigned statements from staff. 6) On 8/10/25, an allegation of sexual abuse involving R89 and R110 was reported immediately to NHA-A. The allegation of sexual abuse was not reported to the State Survey Agency within 2 hours. Staff reported that R89 was inappropriately touching R110 under R110's shirt. NHA-A was immediately informed. Staff were instructed to place R89 on 1:1 supervision. NHA-A stated that the inappropriate touching did not happen. The facility had a soft file of typed unsigned statements from staff. On 9/2/25, at 12:16 PM, Surveyor interviewed NHA-A as to why NHA-A did not report the allegations of abuse and resident to resident altercations. NHA-A confirmed that NHA-A is responsible for coordinating and submitting facility reported incidents (FRI) to the State Survey Agency. NHA-A stated that with all 6 allegations that witnesses indicated that the allegations did not happen as initially reported so there was no need to submit to the State Survey Agency. NHA-A indicated NHA-A has “erred on the side of caution” and reported other incidents. Surveyor shared the concern with NHA-A that once the allegation of abuse is reported, the facility has an obligation to report immediately to the State Survey Agency, including notifying law enforcement if required. The facility has provided no further information at this time. 7) On 8/15/25, R116 and R69 had a resident to resident altercation. The facility conducted an investigation into the incident, but the completed investigation was submitted late to the State Agency on 8/25/25. On 9/29/25 at 1:23 p.m. Surveyor interviewed NHA-A. Surveyor asked NHA-A why the completed self report investigation was submitted late to the State Agency. NHA-A stated she forgot because she had a family emergency, and it was submitted late.

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	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not timely report and thoroughly investigate allegations of abuse (sexual, physical, and verbal) and did not take proactive steps to prevent further potential abuse. This has the potential to affect all 30 residents on the dementia unit. The facility did not ensure that residents on the unit were protected while the investigation should have been in progress. R89 has a history at the facility of resident-to-resident incidents including punching residents and yelling and swearing at other residents. In addition, R89 has grabbed arms, kicking and punched and hit staff in the face during cares. Supervision for R89 was only increased at time of incidents but then was not continued to prevent further incidents. *On 4/19/25, an allegation of resident-to-resident altercation involving R89 and R122 was reported immediately to Nursing Home Administrator (NHA)-A. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. *On 6/4/25, R89 was observed in R110's room, a female resident with a history of sexual assault was inappropriately sexually touched by R89. R89 was on R89's knees at R110's bedside. R110's brief was off, was not covered with a sheet or blanket, and R89 was observed with R89's hand on R110's vaginal area. The allegation of sexual assault was not reported to the State Survey Agency within 2 hours, was not reported to law enforcement, and was not thoroughly investigated. *On 8/10/25, R89 was observed to have R89's hand under R110's shirt. The allegation of abuse was not reported to the State Survey Agency within 2 hours and was not thoroughly investigated. *On 4/19/25, R89 was observed punching R122 in the face in which R122 sustained a skin tear to the left cheek. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. *On 6/28/25, R89 was observed verbally abusing and physically threatening R39. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. Staff reported R106 is known to have physical aggression towards R121 and staff reported observed escalating behaviors of R106 towards R121. The facility did not ensure R121 was free from verbal and physical abuse by R106 residing in the facility. *On 3/17/25, R106 was observed repeatedly hitting R121 with a pillow. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. *On 4/30/25, R106 was heard to physically threaten R121 by stating R106 wanted to cause bodily harm and cause bleeding. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/30/25, R64 and R46 were involved in an unwitnessed physical altercation which resulted in R64 receiving a red mark and 2 small cuts to the right side of her face. On 9/5/25, R64 and R46 were in the dining room without staff providing one-to-one monitoring and again got into a physical altercation. R64 was struck by R46 leaving her with a small scratch to the right side of her face, her left cheek was red, and left eye was slightly swollen. Both resident-to-resident altercations were not thoroughly investigated. R64 alleged that R37 said R37 would hurt R64. The investigation was not thoroughly investigated as no staff were interviewed to see if they had any knowledge of this or any previous concerns regarding R37. The failure of the facility to immediately report allegations of abuse to the State Survey Agency, its failure to complete a thorough investigation of the allegations of abuse, and its failure to put measures in place to prevent further potential abuse led to the finding of Immediate Jeopardy (IJ), which started on 3/17/25. On 9/2/25, at 4:28 PM, Nursing Home Administrator (NHA)-A, and Director of Nursing (DON)-B were informed of the Immediate Jeopardy. The Immediate Jeopardy was removed on 9/30/25. The deficient practice continues at a scope and severity (S/S) of an E (potential for harm/pattern) as the facility continues to implement its action plan. Findings Include: The facility's Abuse, Neglect and Exploitation policy and procedure last reviewed/revised 7/12/25 documents: “Guideline: It is the guideline of this facility to provide protections for the health, welfare and rights of each Resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility has zero tolerance stance around founded abuse, neglect, exploitation and misappropriation of resident property.”… …2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. 3.The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written… …”V. Investigation of Alleged Abuse, Neglect, and Exploitation A. An immediate investigation is warranted when suspicion of abuse. neglect, or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1.Identifying staff responsible for investigation 2.Exercising caution in handling evidence that could be used in a criminal investigation 3. Investigating different types of alleged violations 4.Identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations 5.Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause 6.Providing complete and thorough documentation of the investigation”… …”VI Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. C. Increased supervision of the alleged victim and residents D. Room or staffing changes if necessary, to protect resident(s) from the alleged perpetrator E. Protection from retaliation F. Providing emotional support and counseling to the Resident during and after the investigation, as needed G. Revision of the resident's care plan if the resident's medical, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse”… …”VII Reporting/Response A. The facility will have written procedures that include: 1.Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury. 2. It is important staff feel comfortable to report all concerns by assuring that reporters are free from retaliation or reprisal. 3. Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint. ”… …”VIII Coordination with QAPI A. The facility has written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. 1. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA Committee. This coordinated effort results in the QAA Committee determining: a. If a thorough investigation is conducted b. Whether the resident is protected c. Whether an analysis was conducted as to why the situation occurred d. Risk factors that contributed to the abuse e. Whether there is further need for systemic action such as: i. Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation ii. Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about iii. Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions. iv. Measures to verify the implementation of corrective actions and timeframes. v. Tracking patterns of similar occurrences. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1.) R89 was admitted to the facility on [DATE] with diagnoses that include Unspecified Dementia, Unspecified Severity with Agitation (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Visual Hallucinations (sensory experiences where a person sees objects, people, or scenes that are not actually present. R89 currently has a legal guardian. R89's Quarterly Minimum Data Set (MDS) completed 5/19/25 documents R89's Brief Interview for Mental Status (BIMS) score to be 0 indicating R89 demonstrates severely impaired skills for daily decision making. R89's MDS documents R89's Patient Health Questionnaire (PHQ-9) score to be 0 R89's MDS also documents R89 has no range of motion (ROM) impairment. R89's care card instructing nursing staff in the care of R89 as of 8/25/25 documents: --Correct R89 when using incorrect words to promote word finding Initiated 7/22/25 R89 has sleep deprivation due to dementia. Initiated 4/9/25 --Assess for underlying physiological illnesses causing sleep loss, assess for level of agitation. Initiated 4/9/25 --Keep environment quiet for sleeping. Initiated 4/9/25 --Obtain a sleep wake history Initiated 4/9/25 R89 has experienced trauma due to (this is blank) Triggers that have potential to re-traumatize me (Provide Examples) Sound, smell, touch, taste, sight, other. (this is blank) Once I experience a trigger, I may display these signs/symptoms: anxiety/edginess, overwhelming, anger/irritability, changes in mood state, nightmares, change in sleep pattern, confusion/disorientation, pain/achiness, muscle tension, extreme alertness/hypervigilance, withdrawal/avoidance of activities, other Initiated 2/24/25 Revised 5/14/25 R89 is at risk for mood impairment due to depression and anxiety Initiated 2/13/25 --Monitor/document/report as needed any risk for harm to self: suicidal plan, past attempt at suicide, risky actions, intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Initiated 2/13/25 --Monitor/record/report to MD as needed mood patterns signs of symptoms depression, anxiety, sad mood as per facility behavior monitoring protocols. Initiated 2/13/25 R89 has behavior problems refusing cares, combative, yelling, grabbing, and displaying loving affection towards females. R89 has hallucinations. Surveyor noted this is not specified. Initiated 2/13/25 Revised 7/11/25 (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated 2/13/25 --If reasonable, discuss R89's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to R89. Initiated 2/13/25 --Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Initiated 2/24/25 --Praise any indication of R89's progress/improvement in behavior. Initiated 2/24/25 --Remind R89 that R89's niece wants R89 to work with staff. Initiated 2/24/25 --Explain all procedures to R89 before starting and allow R89 extra time to adjust to changes. Initiated 4/15/25 --Offer a quiet setting. Initiated 4/15/25 --Caregivers to provided opportunity for positive interaction, attention. Stop and talk with R89 as passing by. Initiated 4/15/25 --Provide support to room. Initiated 4/15/25 --Re-approach R89 when initially unapproachable. Initiated 4/15/25 --Allow R89 time to be more independent with cares. Initiated 5/7/25 --Offer coffee per R89's preference to help assist with cares. Initiated 5/14/25 --Offer R89 a shower once a day. R89 is calmer after receiving shower. Initiated 7/11/25 --Monitor for hallucinations. Initiated 7/11/25 --R89 enjoys watching funny animal videos. Initiated 7/17/25 --When becoming agitated offer to take R89 outside. Initiated 7/21/25 --R89 to be 1:1 when out of room. Initiated 8/3/25 R89's Trauma Informed Care completed 6/4/25 documents R89 has experienced physical assault. On 6/24/25 an allegation of abuse was reported between R89 and R110. R110 was admitted to the facility on [DATE] with diagnoses that include Bipolar (episodes of mood swings ranging from depressive lows to manic highs) and Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities),. R110 currently has a legal guardian. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R110's Quarterly Minimum Data Set (MDS) completed 7/25/25 documents R110 demonstrates severely impaired skills for daily decision making with recent and remote memory loss. R110's MDS documents R110's Patient Health Questionnaire (PHQ-9) score to be 0. R110's MDS also documents R110 has no range of motion (ROM) impairment. R110's care card instructing nursing staff in the care of R110 as of 8/25/25 documents: -9/10/24 Keep door open at night as R89 allows to anticipate needs R110 is high risk based upon sex offender and behavior evaluation. R110 shows sexual urges through masturbation. R110 has not made any sexual behaviors towards staff or peers. R110 has poor understanding of safety for self. Initiated 2/27/24 --Report sexual behaviors to charge nurse or social worker. Initiated 2/27/24 R110 has a behavior problem R110 will sit on the floor, sleeping without R110's clothes on and crawl around, sexual behaviors, and exit seeking. Created 2/6/24 Initiated 5/22/25 --If reasonable, discuss R110's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to R110. Initiated 2/6/24 --Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated 2/6/24 *On 6/4/25, an allegation of sexual abuse involving R89 and R110 was immediately reported by Anonymous (Anon)-Q to Unit Manager (UM)-F. Anon-Q reported that R89 was observed in R110's room. R110 was in a low bed to the ground, without a brief on, and no sheet or blanket covering R110. R89 was observed kneeling on R89's knees next to R110's bed with R89's hand on R110's vaginal area. Anon-Q wrote out a written statement. Human Resources (HR)-L also provided a written statement as HR-L had been walking with Anon-Q at the time. On 8/25/25, at 2:30 PM, Surveyor interviewed Anon-Q. Anon-Q informed Surveyor that Anon-Q observed R89 touching R110 on R110's vaginal area. Anon-Q described that R89 was out of R89's wheelchair on R89's knees next to R110's bed which was in the lowest position. R89's hand was on R110's vaginal area. R110's brief was off and R110 was uncovered with no sheet or blanket. Anon-Q stated Anon-Q had to physically lift R89 up and position R89 back in R89's wheelchair and removed R89 from R110's room. Anon-Q immediately informed Unit Manager (UM)-F. Anon-Q stated that R89 and R110 would often be together and R89 would go into R110's room. Anon-Q stated that R89 has always been “touchy feely” with R110. Anon-Q stated staff were always trying to separate R89 and R110. Anon-Q wrote a statement of what Anon-Q observed and was told by administration to “keep an eye on him”. Anon-Q was informed NHA-A had to look at “tapes.” Staff was informed that R89 was only in R110's room for 30 seconds so nothing could have happened. On 8/25/25, at 3:44 PM, NHA-A informed Surveyor that the camera tapes from 6/10/25 have been taped over. NHA-A stated that the camera footage only goes back to 7/18/25. NHA-A informed Surveyor that R89 was not in R110's room long enough for anything to happen. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/26/25, at 8:07 AM, Human Resources (HR)-L informed that HR-L submitted a written statement. HR-L did observe R89 in R110's room, but HR-L stated that HR-L did not see R89 touching R110. HR-L did observe that R110 was not wearing a brief and heard Anon-Q ask R110 if R110 was ok. On 8/26/25, at 2:01 PM, Surveyor interviewed Unit Manager (UM)-F. UM-F is aware of R89 going into R110's room. UM-F stated that UM-F helped interview R89 and R110 as instructed. UM-F denies instructing anyone to complete vaginal checks of all females on the unit after the incident between R89 and R110. UM-F is aware of R89 going into R110's room. UM-F stated that when R110 is unclothed, R110's door should be shut and the stop sign put across the doorway. On 8/26/25, at 9:00 AM, NHA-A informed Surveyor that both the “CNA and HR” had said R89 never touched R110. NHA-A stated that NHA-A watched cameras and that it “was less than 10 seconds” that R89 was in R110's room. NHA-A stated that both R110 and R89 were interviewed about the incident and both R110 and R89 denied. Surveyor questioned how R110 and R89 with severely impaired skills could understand the questions being asked. NHA-A stated it was okay because they were interviewed right after and would have given valid answers despite their severely impaired cognitive skills, memory impairment documented in both R110 and R89's electronic medical record (EMR). On 8/26/25, Surveyor was provided a “soft file” by NHA-A. Statements obtained by NHA-A via phone indicates staff did not observe anything and camera footage indicated R89 was not in the room for more than 28 seconds. The typed staff statements are not signed by the employee and only signed by NHA-A. UM-F and DC-M provided statements that R89 and R110 denied any interaction dated 6/4/25. All other typed staff statements are dated 6/5/25. On 8/26/25, at 10:06 AM, Anon-Q again provided the exact same details of the sexual assault between R89 and R1as in previous interview. Anon-Q confirmed that R89 was touching R110's vaginal area. Anon-Q confirmed putting a statement in writing. The allegation of sexual assault was not reported to the State Survey Agency within 2 hours, was not reported to law enforcement, and was not thoroughly investigated. The care plan was not updated to protect other residents from further potential abuse. On 8/25/25, at 10:54 AM, Surveyor asked Anonymous (Anon)-N about the allegation of R89 between R89 and R110 on 6/4/25. Anon-N stated, “that's an interesting question because it was not on the 24-hour board”. The 24-hour board is the nurse's communication between nurses. Anon-N is aware that a ‘sexual assessment' was completed on every female resident on the unit. Anon-N also informed Surveyor that R89 had an incident of being sexually inappropriate the day before 6/4/25. Anon-N stated that R89 was known to get into other resident rooms. Anon-N describes R89 as confused, agitated, and not easy to redirect. Anon-N states that R89 gets triggered very easily. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/25/25, at 1:01 PM Anonymous (Anon)-P informed Surveyor that Anon-P was aware of the allegation of sexual abuse between R89 and R110. Anon-P stated that NHA-A stated it never happened. Anon-P informed Surveyor that R110 frequently takes off R110's brief and prefers to have R110's brief off and pull legs up into chest almost like in the ‘fetal position'. Anon-P also stated it was common for R89 to wander in and out or rooms and was attracted to R110. Anon-P stated that R110 would frequently take off R110's brief and be in bed naked from the waist down. Anon-P stated administration knew that R89 was obsessed and attracted to R110. Anon-P informed Surveyor that it was a common thing for R110 to take R110's briefs off and go up into the fetal position, with R110's legs open so it could have easily happened with R89 touching R110 in the amount of time administration is stating R89 was in the room. On 8/26/25, at 7:35 AM, Social Worker (SW)-D cannot remember anything that happened in June between R89 and R110 but was informed of the incident between R89 and R110. SW-D stated that R110 likes to sleep naked and R89 went into R110's room. SW-D was informed that R89 was not in R110's long enough for anything to happen. SW-D described R89 to be agitated and will yell. SW-D stated that R89 will wander into other rooms. SW-D stated that R89 likes R110 and has been in R110's room, and staff are supposed to keep a close on R89. On 8/26/25, at 8:10 AM, Anonymous (Anon)-R informed Surveyor that R89 can be very much sexually inappropriate and is sexually aggressive with words. Anon-R was informed to keep an eye on R89. Anon-R stated that R89 has had multiple resident-to-resident altercations. Anon-R stated that Anon-R stays clear of R89 because R89 punched Anon-R in the mouth causing injury. On 8/26/25, at 2:38 PM, Director of Nursing (DON)-B informed Surveyor that there was “not enough time for anything to happen”. DON-B then stated that NHA-A “was a big part of the investigation.” DON-B informed Surveyor that R89 was only in the room for 9 seconds so there was not enough time to do anything. Surveyor asked DON-B about who instructed nursing staff to complete vaginal checks on the female residents on the unit. DON-B does not know and was not aware this was done. On 8/26/25, Surveyor on the team conducted an EMR review of all female residents on the unit. Currently there are 19 females. On 6/4/25, a nurse documented a ‘vaginal assessment' was completed on two female residents and a third female resident refused the vaginal assessment. On 8/26/25, at 3:31 PM, Dementia Coordinator (DC)-M informed Surveyor that DM-M was instructed to perform an inspection of all the females on the unit by NHA-A. DC-M described an inspection as providing incontinence cares and DM-M was checking for drainage and redness. Surveyor asked DC-M why DC-M was completing this task. DC-M stated, “that was the day R89 was in R110's room”. DC-M stated it was completed in an “abundance of care”. DC-M stated that DC-M completed on 3 residents including R110 but then was told to stop by NHA-A. DC-M did not document this task. DC-M stated that DC-M was looking for redness in the vagina area, discharge in the brief of the female residents. DC-M then stated that vaginal check was really “an inspection.” DC-M stated that not all residents were inspected because R89 was not in the room long enough because it was a ‘brief short moment in time” and there was no contact. *On 8/10/25 a second allegation of abuse involving R89 and R110 was reported. Anonymous (Anon)-W documented in R89's electronic medical record (EMR): (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	…”Writer was notified by CNA that R89 tried to put his hand under R110's shirt. When R89 was redirected, R89 became very agitated. Writer notified DON and supervisor. Per DON to start 1:1 with R89 and monitor behaviors.”… On 8/27/25, at 3:51 PM, NHA-A informed Surveyor that there was camera footage, and it never happened, but there is a soft file that NHA-A will provide. Surveyor shared the concern that an allegation of R89 putting R89's hand under R110's shirt was not reported to the State Agency and a thorough investigation was not completed. On 8/28/25, at 8:25 AM, Surveyor observed the camera footage. At 1.04.24, Surveyor observed R110 in R110's wheelchair with R110's legs up in the air, in the hallway next to the handrail. At 1.04.31, R89 comes up from behind, and 1.04.43, pulls R110's wheelchair closer to R89. At 1.04.54, R89 grabs R110's hands with left hand and right hand goes to bottom of R110's shirt. An unknown resident approaches both R110 and R89 and stands in front of both R110 and R89 and a clear view is obstructed. At 1.05.28, R110 pulls arms and hands away from R89. At 1.05.36, R89 grabs R110's hands again and places R89's hands with R110's hands close or on R110's chest. At 1.05.53, Anonymous (Anon)-HH is observed coming behind R110 and pulled R110 backward towards the dining room. R89 is observed following R110. On 8/28/25, at 9:18 AM, Surveyor left message for Anon-HH and did not receive a call back during the survey process. On 8/28/25, at 9:27 AM, Surveyor spoke with Anon-W. Anon-W stated it was Anon-W's first time working the unit. Anon-W stated a CNA reported to Anon-W that R89 was attempting to put R89's hand under R110's shirt. Anon-W reported to administration right away and was instructed to place R89 on 1:1 supervision right away and keep R89 and R110 separated. Surveyor reviewed the facility's provided soft file statements. Anon-W's statement states that Anon-HH reported R89 touching R110 inappropriately. The statement obtained by the facility does not specify what the inappropriate touching was. Anon-HH's facility statement also does not refer to what the inappropriate touching was. The typed facility staff statements are not signed by the employee or administration. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/2/25, at 12:16 PM, Surveyor interviewed NHA-A in regard to R89 and R110's allegation of sexual abuse. NHA-A stated that R89 was in R110's room for “seconds”. NHA-A stated, because R89 was only in the room for seconds, nothing could have happened. NHA-A states “CNA saw R89 still in R89's chair”, and then stated “R89 was observed trying to climb out of the chair”. NHA-A stated that NHA-A would have reported if there were witnesses who reported that R89 “actually” touched R110. Surveyor provided information from interviews to NHA-A. “If I had statements, I would have reported it.” NHA-A stated, “If people would just tell us the truth. I don't get why they would not be honest. I can't help staff lie. What can I do when they lie?” NHA-A confirmed a facility reported incident was not submitted to the State Survey Agency. Surveyor spoke with NHA-A about the 8/10/25 incident between R89 and R110 and the allegation of inappropriate touching. NHA-A stated that the call went to DON-B and that R89 and R110 were only holding hands which the families are okay with. NHA-A stated that staff “thought something could happen but never saw anything.” Surveyor shared the allegation was documented and R89's care plan with interventions was not updated and put in place to prevent further abuse from occurring. Surveyor share the allegation should have been reported to the State Agency. NHA-A confirmed that the incidents had not been reported to the State Agency. Surveyor notes that a thorough investigation was not completed in regard to the allegation of R89 inappropriately sexually touching R110 two times. NHA-A confirmed that NHA-A did not believe the incidents happened between R89 and R110, despite staff expressing it did based on observations. Surveyor notes there is no Misconduct Incident Report submitted by the facility to the State Survey Agency. 2.) R122 was admitted to the facility on [DATE] with diagnoses of Alzheimer's(progressive disease that destroys memory and other important mental functions), Unspecified Dementia, Severe, with Agitation(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Essential Hypertension(most common type of high blood pressure), and Anemia(lack of blood). R122 had an activated Health Care Power of Attorney (HCPOA) while at the facility. R122's admission MDS documents R122 has recent/remote memory loss and demonstrates severely impaired skills for daily decision making. R122's MDS documents R122 has continuous inattention. R122's Patient Health Questionnaire (PHQ-9) scored a 2 indicating minimal depression. R122's MDS also documents physical and verbal behaviors and rejection of care 1-3 days and wandering 4-6 days. R122 has no range of motion (ROM) impairment. R122 requires partial/moderate assistance for eating and upper dressing. R122 requires substantial/maximum assistance for showers and lower dressing. R122 is independent for mobility and transfers. *On 4/19/25, an allegation of resident-to-resident altercation between R89 and R122 was reported immediately to NHA-A. It was reported that R89 had punched R122 in the face causing a skin tear to the left cheek. On 8/25/25, at 1:01 PM, Surveyor interviewed Anonymous (Anon)-P in regard to the incident between R89 and R122. Anon-P stated that R89 thought R122 had called R89 a clown. R89 swung out and Anon-P heard R122 say “ouch.” Anon-P observed a small cut on the outside of R122's left cheek. It was reported that NHA-A stated that NHA-A watched cameras, and it never happened and that R122 bit the inside of R122's lip. Anon-P stated R122 had a fresh injury on the outside of R122's left cheek. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed R122's EMR and notes that R122 has a completed initial wound assessment dated [DATE] that documents R122 has a new skin tear to the face, however, no other details are documented. On 8/26/25, at 10:42 AM, Surveyor interviewed Anonymous (Anon)-S in regard to the incident between R89 and R122. Anon-S stated that Anon-S was present the night R89 punched R122. Anon-S heard the punch. Anon-S was at the nurse's station and R89 and R122 were in front of the nurse's station. Anon-S back was turned at the time, but Anon-S heard the punch. Anon-S observed R89 have a stance like R89 had just hit R122 and R122 was holding R122's lip. Anon-S reported it immediately to NHA-A. Anon-S was then informed by NHA-A that NHA-A had watched the cameras and R122 had hit R122's self. Anon-S stated that R122's cheek had to be cleaned and treated. Anon-S stated that R89 is physically aggressive with other residents. On 8/27/25, at 3:51 PM, Surveyor interviewed NHA-A about the incident between R89 and R122. NHA-A stated that R122 bit the inside of R122's cheek and nothing happened because the CNA stated R89 and R122 never connected. NHA-A confirmed there is no facility soft file with s

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	525281	A. Building B. Wing	09/30/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0644 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 record review and interview, the facility did not incorporate the recommendations from the Preadmission Screen and Resident Review (PASARR) Level 2 determination and evaluation report into a Resident's assessment, care planning, and transitions of care for 1 (R11) of 1 Resident reviewed with PASARR level 2 recommendations. *R11's PASARR dated 7/28/25 determination states R11 requires intensive, continuous treatment program called specialized services to address R11's intellectual/developmental disability or mental illness.Findings Include:The facility's Specialized Rehabilitative Services revised 11/11/24 documents:.The facility shall provide or obtain services from an outside resource for specialized rehabilitative services if required by the resident's comprehensive assessment and care plan. These services will assist them in attaining, maintaining, or restoring their highest practicable level of physical mental functional and psycho-social well-being. It will also ensure that residents with Mental Disorder(MD), Intellectual Disability(ID) or related conditions receive services as determined by their Preadmission Screening and Resident Review (PASARR) .1.Specialized rehabilitative services include but are not limited to the following:a. Physical therapyb. Speech-language pathologyc. Occupational therapyd. Respiratory therapye. Specialized services for mental illness or intellectual disability (those services to be provided by the State in accordance with the PASARR report)f. Mental health rehabilitative services for mental illness and intellectual disability or services of a lesser intensity(those services to be implemented by facility staff regardless of whether or not they are required to be subject to the PASARR process)2.Specialized rehabilitative services will be provided under the written order of a physician by qualified personnel.3.The services will be provided or coordinated by qualified personnel. In-house providers and outside resource providers shall not be excluded from participating in any federal or state health care program.4.The care plan for individuals receiving specialized rehabilitative services will be monitored and revised as indicated by a licensed professional.R11 was admitted to the facility on [DATE] with diagnoses of autistic disorder, repeated falls, unspecified intellectual disabilities, epilepsy, Mood [Affective] Disorder, anxiety disorder and gastrostomy (surgical procedure that creates an opening in the stomach through the abdominal wall to allow for feeding and medication administration directly into stomach). R11 currently has a legal guardian.R11's Level I screen summary indicates R11 has a major mental disorder, has displayed symptoms that suggest the presence of a major mental illness and receives psychotropic medications to treat the symptoms or behaviors of a major mental disorder. The Level I also documents that R11 has a diagnosis of cerebral palsy, epilepsy, autism, brain injury or intellectual/developmental condition other than mental illness, that results in impairment of general intellectual function or adaptive behavior similar to that of the intellectual disabled persons, and requires treatment or services similar to those required for these persons and was manifested before the person was age [AGE].R2's Level II completed 7/28/25 documents R11 requires intensive, continuous treatment program called specialized services to address R11's intellectual/developmental disability or mental illness. It further documents, .R11 is in need of specialized services at this time. R11 has a diagnosis of autism, intellectual disability and behavior disturbance. The focus of specialized services is to maintain or improve R11's current level of functioning. Specialized services should include a thorough assessment of R11's unique capabilities and functional limitations by a QIDP (qualified intellectual disabilities professional) . R11 would benefit from physical/occupational therapy to improve self-cares, mobility, and strength. Staff should monitor for signs of nonverbal communication. R11 should be approached in a positive manner. Opportunities for socialization, sensory stimulation and leisure should be provided. R11 should be involved in daily decision making as able. Needs appropriate interventions and redirection for maladaptive behavior. Caregivers and staff whom are familiar with R11 should be involved in R11's plan of care as they are familiar with R11 .The assessment completed on 7/28/24 for persons with intellectual/developmental disabilities documents the following for R11:-R11 currently requires increased assistance for activities of daily living. Therapies should focus on strengthening and increasing independence with self-help skills.-R11 currently requires increased assist with sensory motor development-R11 does not make R11's needs known to staff. Staff should observe for nonverbal communication and allow opportunities for R11 to express R11's preferences and desires.-R11 should be given simple one step directions and given extra time and repetition for processing as needed.-R11 should be encouraged to participate in independent living skills as able. R11's caregiver notes that R11 was more independent and participatory with independent living skills in the

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	525281	A. Building B. Wing	09/30/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0677 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 observation, interview and record review the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and assistance with repositioning for 1 of 2 (R60) residents reviewed for ADL's (Activity of Daily Living).R60 was not provided assistance to reposition as she requested until Surveyor intervened and asked staff to assist the resident.Findings include:R60 was admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3, chronic obstructive pulmonary disease, morbid obesity, asthma, dysphagia, anxiety disorder, major depressive disorder, hypertension, gout, gastroesophageal reflux disease and hereditary and idiopathic neuropathy.R60's BIMS (Brief Interview for Mental Status Score) dated 7/28/25 documents a score of 15, indicating no cognitive impairment.R60's admission MDS (Minimum Data Set) dated 8/3/25 documents: Functional Limitation in Range of Motion lower extremity (hip, knee, ankle, foot) - impairment on both sides.Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed - partial/moderate assistance. R60's Admission/readmission/routine Head to Toe Evaluation dated 7/28/25 documents: Fall Risk evaluation - High risk.R60's Physical Therapy Discharge summary dated [DATE] documents: Bed mobility roll left and right = Substantial/maximal assistance.On 9/22/25 at 11:55 AM, Surveyor observed R60 lying in bed on her back, wearing a gown. R60 told Surveyor she wanted to get boosted up in bed, But the aid said she can't help me because she don't want to hurt her back. Surveyor offered to find someone to assist R60. R60 stated, Yes, but she won't because she don't want to hurt her back. Surveyor put R60's call light on and within a minute Certified Nursing Assistant (CNA)-FF entered the room and turned off the call light. Surveyor told CNA-FF that R60 would like to be repositioned and boosted up in bed. R60 stated to CNA-FF Tell her what you tell me, you can't because you don't want to hurt your back. CNA-FF stated, I can't by myself, I have to get someone to help me and left the room. On 9/22/25 at 12:15 PM, Surveyor noted R60 remained in the same position on her back and noted R60 had slid down more near the middle of the bed. Surveyor asked if anyone had been in to reposition her yet. R60 stated, No. I told you, she won't because she don't want to hurt her back. Surveyor observed a different CNA in the dining area where 3 residents were seated eating lunch. Surveyor observed CNA-FF enter another resident's room.On 9/22/25 at 12:25 PM, Surveyor observed no staff had been in R60's room to reposition/boost her up in bed as requested. Surveyor observed CNA-FF passing lunch trays to resident rooms. Surveyor reminded CNA-FF that R60 had asked to be boosted in bed and asked if she has been in her room to reposition her. CNA-FF stated, No, the other aid had to stay in the dining room, so I was alone out here. Surveyor asked CNA-FF if she asked anyone else for assistance, such as the nurse, to help her reposition R60. CNA-FF stated, No, now I'm passing trays. It had been 30 minutes since Surveyor and R60 requested assistance.On 9/22/25 at 12:33 PM, Surveyor entered R60's room, noting she had not been repositioned or boosted in bed. R60 had received her meal tray. Surveyor asked R60 if she was having lunch. R60 was tearful and replied (with voice cracking), My back hurts, I need to be boosted. I can't eat now, I'm not hungry, my back hurts. On 9/22/25 at 12:35 PM, Surveyor approached Licensed Practical Nurse (LPN)-Y who was standing at the medication cart at the nurse's station. Surveyor advised LPN-Y that R60 is uncomfortable, tearful and asked to be repositioned 40 minutes ago. Surveyor asked LPN-Y if he would help the CNA reposition the resident. LPN-Y stated, Absolutely, I'll go down there right now. Surveyor observed LPN-Y and another staff member enter R60's room. On 9/22/25 at 1:10 PM, Surveyor observed R60 positioned more upright in bed, with pillows on each side. When asked how she was feeling, R60 stated, Better, thank you. Surveyor asked her if now that she was boosted in bed, is she going to have lunch. R60 stated, No, I'm not hungry now, just forget it. Surveyor noted the CNA Point of Care documentation enter on 9/22/25 at 1:00 p.m. indicated R60 consumed 75% of her meal, when in fact the resident did not eat lunch.

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	525281	A. Building B. Wing	09/30/2025

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure its procedures for indicating a residents' code status was followed for 1 (R11) of 20 residents sampled.R11 did not have a current physician order for R11's code status.Findings Include:The facility's policy and procedure Communication of Code Status revised 4/1/25 documents: .Explanation and Compliance Guidelines:2. When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. 3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record.4. The designated sections of the medical record are: physician orders obtained per election form and uploaded signed election form.R11 was admitted to the facility on [DATE] and has a legal guardian. On 9/22/2025, at 12:55 PM Surveyor completed a record review and notes that on 7/7/25, R11's guardian signed for R11 to be full code status. Surveyor noted on R11's current physician orders, there is no order for full code status.On 9/23/2025, at 1:53 PM, Surveyor received a copy of R11's current physician orders and confirmed R11's full code status is not documented in R11's current physician orders On 9/23/2025, at 1:55 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-MM. LPN-MM stated that the nurses have basic information for each resident on the unit which includes the code status of each resident. R11's code status documents full code. LPN-MM stated that LPN-MM would also double check in the resident's electronic medical record (EMR). Both Surveyor and LPN-MM pulled up R11's EMR and LPN-MM confirmed that R11 does not have a current code status listed. On 9/23/2025, at 10:14 AM, Surveyor interviewed Social Worker Assistant (SWA)-D in regard to code status. SWA-D stated that SWA-D had nothing to do with obtaining code status or maintaining the code status in a resident's EMR. SWA-D will verify in the care conference of what the code status is. Surveyor notes that R11 has not had a care conference.On 9/24/2025, at 2:57 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the concern that R11's current physician orders to not have an order for R11's full code status. NHA-A stated the expectation is that there should be a physician order for code status for each Resident.On 9/25/2025, at 8:12 AM, NHA-A informed Surveyor that the facility conducted an audit of every Resident to verify there was a physician order for code status.

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	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 3 (R101, R131 and R50) of 3 resident received necessary care and treatment. On 8/25/25, R101 had signs and symptoms of a urinary tract infection (UTI) and an order for a urinalysis with culture and sensitivity was obtained. The urine sample was not processed. On 9/4/25, R101 had an order for a wound culture and the specimen was obtained and not stored properly. Another specimen was not obtained until 9/9/25 delaying treatment to an infected wound R131 was admitted to the facility on [DATE] with surgical wounds to the left leg. A comprehensive wound assessment was not completed until 8/13/2025. R131 did not have monitoring or treatments to the left leg surgical wounds until 8/12/2025. On 9/24/25 R50 was observed to have pericare performed and 2 incontinent briefs were placed on R50. Findings include: 1) R101 was admitted to the facility on [DATE] with diagnoses of paraplegia and chronic obstructive pulmonary disease (COPD). The quarterly minimum data set (MDS)dated 6/26/25 documents R101 is cognitively intact. The care plan dated 5/10/22 documents R101 has a foley catheter due to neurogenic bladder. The nurses note dated 8/25/25 documents R101 was not feeling well with cold sweats, shivers, increased lethargy and decreased appetite. Vital signs documented was temperature 98.6, pulse 99, blood pressure 71/55. Nurse Practitioner (NP)-K was made aware of R101's symptoms and ordered a UA (urinalysis) with culture to be collected. On 9/24/25 at 3:00 p.m. during the daily exit meeting with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A, Surveyor asked for a copy of the UA collected on 8/25/25. On 9/25/2025 at 9:38 a.m., DON-B gave Surveyor a Mcgeers Infection Symptom Tracking form dated 8/26/25. DON-B stated R101 did not fit the criteria for infection and the UA was cancelled. Surveyor asked about R101's symptoms such as chills, cold sweat, increased lethargy and blood pressure below normal. DON-B stated these symptoms were normal for R101. Surveyor reviewed R101 blood pressure history. There is no evidence R101 has a normal chronically low blood pressure. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Mcgeers criteria for a catheter associated urinary tract infection documents the following:Must have at least one of the following:a. Fever, rigors or new onset hypotension (low blood pressure) with no alternate site of infection.b. Either acute change in mental status or acute functional decline with no other DX (diagnosis) and leukocytosisc. New onset suprapubic pain or costovertebral angle pain or tendernessd. Purulent discharge from around catheter or acute pain, swelling, tender testes, epididymis or prostrateAndUrine has >10 (5) CFU.ML of any organism(s) obtained after catheter replaced if catheter in for more than 14 days. Based on the guidelines and R101's blood pressure readings, R101 would have met the Mcgeers criteria and a UA may have been appropriate. On 9/25/25 at 8:24 a.m. Surveyor interviewed RN-NN. RN-NN was the nurse that documented R101 symptoms on 8/25/25. Surveyor asked RN-NN why she contacted NP-K on 8/25/25 regarding R101. RN-NN stated R101 was exhibiting symptoms similar to sepsis and that is why she contacted NP-K to get an order for a UA. RN-NN stated R101's symptoms didn't seem as bad as they had been in the past when he was sent to the hospital for sepsis. RN-NN stated R101 will go through cycles where he will get sick then need to go to the hospital and then he will be fine for several months. Surveyor explained to RN-NN that R101's UA was cancelled due to not meeting Mcgeers criteria for infection. RN-NN stated she was not made aware of that information. On 9/30/25 at 9:11 a.m. Surveyor interviewed Director of Ops-YY. Surveyor explained the concern R101 symptoms met the Mcgeers criteria for infection based on the symptoms documented by RN-NN. Director of Ops-YY stated she agreed R101 symptoms did meet criteria and thinks DON-B was thinking R101 did not have a catheter. Director of Ops-YY stated the UA should not have been cancelled. 2) R101's nurses note dated 9/3/25 documents Wound MD called-Right groin wound noted to have increase in drainage this AM-Purulent drainage. Wound MD changed treatment to BID (twice a day) and to Culture wound with next treatment change. Resident, Unit Manager, and Primary MD aware. The nurses note on 9/4/25 documents swab specimen obtained of right groin wound. There was no result of this sab in the medical record. A wound culture result was dated 9/12/25 documenting rare streptococcus Group G. On 9/25/25 at 9:53 a.m. Surveyor interviewed ACL Rep-SSS. Surveyor asked ACL-Rep-SSS if a wound swab was ordered on 9/4/25 for R101. ACL-Rep-SSS stated an order was not placed on 9/4/25 but on 9/9/25 and it had resulted on 9/12/25. On 9/25/25 at 9:23 a.m. Surveyor interviewed RN-UU. RN-UU is the nurse that documented obtaining the swab specimen to the right groin. Surveyor asked RN-UU if she swabbed R101 right groin wound on 9/4/25. RN-UU stated she did swab the wound and placed the sample in the lab refrigerator. RN-UU stated she didn't realize the sample had to be at room temperature and not refrigerated temperature and so it was not picked up by the lab. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/25 at 1:04 p.m. Surveyor interviewed Wound Nurse-EE. Surveyor asked if she was aware R101's wound swab that was collected was not picked up by the lab due to RN-UU erroneously putting the sample in the refrigerator. Wound Nurse-EE stated she was not made aware of it until the following week. Wound Nurse-EE stated she works once a week on Tuesday at the facility. Wound Nurse-EE stated when she was made aware of the error on 9/9/25 they collected another wound sample. Wound Nurse-EE stated R101 was then treated with IV (intravenous) antibiotics for the wound infection. 3) R131 was admitted to the facility on 8/6 2025 and has diagnoses that include displaced fracture of base of neck of left femur, displaced subtrochanteric fracture of left femur, displaced bicondylar fracture of right tibia, unspecified injury of femoral artery on the left leg, and type 2 diabetes mellitus. R8 was assessed on 8/6/2025 to have intact cognition with Brief Interview of Mental Status Score (BIMS) score of 15 and the facility assessed R131 on admission requiring assistance of one staff member with activities of daily living (ADLs). R131 was admitted 4 surgical incision areas on R131's left leg, R131 was assessed on 8/6/2025 to be at moderate risk for skin impairment with a Braden score of 17. R131 was discharged to another facility on 8/20/2025. On 8/6/2025, at 17:17 (5:17 PM), in the progress notes director of nursing (DON)-B documented (R131) admitted from [Hospital name] … (R131) was in motorcycle accident that resulted in left lower extremity (LLE) damage including femur fracture, tibia/fibula fracture, severed femoral artery. (R131) had external fixation device in place prior to open reduction and internal fixation (ORIF- surgical procedure used to treat bone fractures and dislocations by realigning broken bones stabilizing them with internal hardware) surgery to femur, fibula and tibia. … wounds to left lower extremity including sutures … Surveyor reviewed R131's admission skin assessment documented on 8/6/2025:-Left lower extremity: upper/ outer hip area- 5 sutures, then 4 inches down, 21 sutures in place. (R131) has ace wraps in place on the lower left leg from the knee down. (R131) states there is also surgical wounds and preferred not to remove the dressings as it was too sore. Surveyor noted that there was not a comprehensive assessment done on R131's surgical incisions to document how long the surgical incision was, how the surrounding skin appeared, if there was drainage noted, etc. On 8/6/2025 R131 care plan was initiated for potential/ actual impairment to skin integrity of the (specify location) r/t with the following interventions:- Assist to turn and/or reposition every 2-3 hours.- Educate resident/family/caregivers of causative factors and measures to prevent skin injury.- Encourage good nutrition and hydration in order to promote healthier skin.- Float heels if resident cannot turn and reposition themselves- Keep skin clean and dry. Lotion skin with cares. Do not apply lotion on (specify site of injury).- Monitor skin during cares. Report to nurse any changes.- Pressure reduction mattress.- The resident needs pressure reducing cushion to protect the skin while up in wheelchair.- Weekly licensed nurse skin evaluation. Surveyor noted the care plan did not specify the locations of impairment to R131's skin integrity. Surveyor reviewed R131's hospital discharge summary from 8/6/2025 and noted the following treatment documented for R131's surgical incisions:-Cover incisions with gauze and tape, change every day until dry for 24 hours and no drainage on the dressing. When dry leave open to air. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R131's medication administration record and treatment administration record (MAR/TAR) and physician orders and noted there was not an order to change/monitor R131's dressings and surgical sites every day. On 8/13/2025 Wound Nurse-EE documented the following assessment for R131's left leg surgical incisions:1. Left hip surgical incision: 24.2cm X 0.3cm X 0 (length X width X depth), no odor or drainage present, staples intact.2. Left medial knee, upper surgical incision: 10.5cm X 0.3cm X 0, no drainage or odor present, sutures intact.3. Left medial knee, lower surgical incision: 5.0cm X 0.3cm X 0, no drainage or odor present, sutures intact. 4. Left lateral knee surgical incision: 22.4cm X 0.3cm X 0, no drainage or odor present, sutures intact. Surveyor reviewed R131's TAR and noted an order that was started on 8/15/2025:-Cleanse surgical wounds to LLE with Saline and pat dry. Cover wounds with border gauze dressing every day shift every other day for wound care. On 8/25/2025, at 12:35 PM, Surveyor interviewed Anonymous-O who stated that R131 had areas to the left leg because R131 was in a bad accident. Anonymous-O stated that Anonymous-O did not do anything to the areas on R131's left leg and was not aware that monitoring or checking the areas had to be done and does not recall if dressing changes had to be done on the AM shift. Surveyor asked how staff is notified if there has to be dressing changes or monitoring for a resident. Anonymous-O stated that it will be on the resident MAR/TAR to be done. On 8/26/2025, at 8:02 AM, Surveyor interviewed Wound Nurse-EE who stated 8/13/2025 was the first time Wound Nurse-EE had seen R131's surgical incisions. Wound Nurse-EE stated licensed nurses should do an assessment on admission or when an area of concern is noted and document the wound location, measurements, if there is drainage or odor present, how the wound bed looks and surrounding skin. Wound Nurse-EE stated that if Wound Nurse-EE is in the facility, Wound Nurse-EE will document the assessment and put in treatment orders, and revise the care plan, otherwise nursing should do it. Surveyor asked Wound Nurse-EE who puts in the orders for residents' treatments. Wound Nurse-EE stated that hospital paperwork will be reviewed and if there are orders or recommendations from the discharge paperwork for staff will need to call the physician to get an order in place. Wound Nurse-EE assessed R131's surgical incisions for the first time on 8/13/2025 and reviewed hospital discharge paperwork. Wound Nurse-EE put in the order to cleanse surgical wounds to LLE with Saline and pat dry. Cover wounds with border gauze dressing every day shift every other day for wound care and to start on 8/15/2025. Wound Nurse-EE was not sure why monitoring or treatments were not implemented to R131's left lower extremity on R131's admission to the facility on 8/6/2025. Surveyor noted on R131's care plan was revised on 8/12/2025 with the following documentation:- The resident has potential/ actual impairment to the skin integrity of the LLE … with the following revised interventions:- Keep skin clean and dry. Lotion skin with cares. Do not apply lotion on LLE … (revised 8/12/2025) Surveyor noted the following revisions to R131's care plan on 8/14/2025:-The resident has potential/actual impairment to skin integrity. 4 surgical wounds, left hip, left lateral knee, left medial upper and left medial leg lower. … (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/2025, at 8:32 AM, Surveyor interviewed DON-B who stated R131's dressing was to be left in place. Surveyor informed DON-B that per R131's discharge paperwork from the hospital on 8/6/2025, R131's surgical dressings to the left leg were supposed to be changed daily and monitored for drainage. Surveyor stated that there were no orders for R131's left leg dressing to be changed daily or left in place and monitored for drainage or status of R131's surgical incisions. Surveyor shared concern that a comprehensive assessment was not completed on R131's surgical incisions until 8/13/2024. DON-B stated that the surgical incisions were documented on 8/6/2025. Surveyor shared that the assessments were not comprehensive and R131 had 4 surgical incisions to R131's left leg. Surveyor shared that the admission assessment for R131's surgical incisions on 8/6/2025 were not comprehensive and was unclear how many areas were noted. DON-B understood and stated would have to look and see what the orders were for R131 when admitted to the facility on [DATE] for R131's left leg incision sites. 4) R50 was admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure with tracheostomy, quadriplegia, epilepsy, gastrostomy feeding tube, and metabolic encephalopathy. R50's admission Minimum Data Set (MDS) assessment dated [DATE] documents R50 is severely cognitively impaired. R50 is dependent for all cares, toileting and mobility. R50 is always incontinent of bowel and bladder. R50's bladder incontinence care plan initiated on 6/16/25 documents the following pertinent intervention: Brief use: The resident uses extra large size disposable briefs. Change every 2-3 hours [frequency] and [as needed]. On 9/24/25 at 9:40 AM, Surveyor observed Certified Nursing Assistant (CNA)-TT and CNA-SS providing morning cares to R50 and transferring R50 from R50's bed into R50's Broda chair. After completing hand hygiene, putting on a gown and gloves, CNA-TT and CNA-SS went to R50's bed. Surveyor noted 2 clean briefs sitting at the end of the bed. Surveyor noted the briefs were piled one on top of the other, opened and ready to be used. R50 was turned onto left side. One used brief was removed. CNA-TT completed peri-care and placed the 2 clean briefs under R50. CNA-TT and CNA-SS rolled R50 onto R50's back and completed putting on the 2 clean briefs on R50. On 9/24/25 at 9:48 AM, Surveyor interviewed CNA-TT. Surveyor asked how often R50 has R50's brief changed. CNA-TT stated every 2 to 3 hours. Surveyor asked if it is common to use 2 briefs on R50. CNA-TT stated that sometimes when R50 is moved, R50 will urinate and that is why 2 briefs were placed on R50. Surveyor asked if R50's briefs are still clean. CNA-TT looked and stated yes. On 9/24/25 at 10:04 AM, Surveyor interviewed CNA-CCC. Surveyor asked if residents can be double briefed. CNA-CCC stated they can only be double briefed if it is part of the CNA Kardex. CNA-CCC stated some residents prefer to be double briefed and, in that case, it would be care planned and the resident's wishes would be followed. On 9/24/25 at 10:08 AM, Surveyor interviewed Registered Nurse (RN)-LLL. Surveyor asked if resident can be double briefed. RN-LLL stated a resident can be double briefed if it is discussed and care planned ahead of time. (continued on next page)

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	09/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/25 at 1:12 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if residents can be double briefed. DON-B stated yes, if that is their choice. Surveyor asked where that information would be documented. DON-B stated it would be documented in the resident's care plan. Surveyor informed DON-B of the concern that Surveyor observed CNA-TT and CNA-SS place R50 into double briefs and R50 does not have a care plan intervention to have double briefs. Surveyor asked if R50 should have been double briefed. DON-B stated only if [R50's power of attorney] wants that. Surveyor asked where that direction would be documented. DON-B stated in R50's care plan. Surveyor reviewed R50's care plan and Kardex and did not locate an intervention directing staff to double brief R50.

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	525281	A. Building B. Wing	09/30/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that resident with pressure injury received necessary treatment and services consistent with professional standards of practice for 3 (R7, R50, and R131) of 8 residents reviewed for pressure injuries. R7 developed a blister to the thumb that declined to a stage 3 pressure injury from R7's palm guard. There were no interventions in place prior to R7 developing the stage 3 pressure injury and the interventions put in place after development were not clear as to what needed to be in place for R7. R50's pressure injury was not staged correctly on admission; a treatment was not put in place for 3 days after admission. On 7/2/25, R50's pressure injury doubled in size. R50's treatment and care plan were not revised after R7's pressure injury worsened. R131 was admitted to the facility on [DATE] with a stage 2 pressure injury to the sacrum. R131 did not have a comprehensive assessment to R131's stage 2 pressure injury until 8/12/2025 and treatment was not initiated until 8/12/2025 to R131's stage 2 pressure injury. Findings include: The facility policy titled “Pressure Injury Prevention and Management” last reviewed/revised on 4/17/2025 documents: “This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. … Explanation and Compliance Guidelines: …2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment and Pressure injury risk: …C. Licensed nurses will conduct a full body skin assessment on all resident upon admission/re-admission, weekly, and after newly identified pressure injury. Findings will be documented in the medical record.D. Assessments of pressure injuries will be performed by a licensed nurse and documented on the medical record. …E. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. …4. Interventions for Prevention to Promote Healing: …d. Evidenced based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. …ii. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics. …f. interventions will be documented … and communicated to all relevant staff. …6. Modifications of Interventions.b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include:i. Changes in resident's degree of risk for developing a pressure injury.ii. New onset or recurrent pressure injury development.iii. Lack of progression towards healing.iv. Resident non-compliance.” (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) R131 was admitted to the facility on 8/6 2025 and has diagnoses that include displaced fracture of base of neck of left femur, displaced subtrochanteric fracture of left femur, displaced bicondylar fracture of right tibia, unspecified injury of femoral artery on the left leg, and type 2 diabetes mellitus. R131 was assessed on 8/6/2025 to have intact cognition with Brief Interview of Mental Status Score (BIMS) score of 15 and the facility assessed R131 on admission requiring assistance of one staff member with activities of daily living (ADLs). R131 was admitted with a hospital acquired stage 2 pressure injury to the sacrum, R131 was assessed on 8/6/2025 to be at moderate risk for skin impairment with a Braden score of 17. R131 was discharged to another facility on 8/20/2025. On 8/6/2025, at 5:17 PM, in the progress notes, Director of Nursing (DON)-B documented R131 was admitted from the hospital following a motorcycle accident that resulted in left lower extremity (LLE) damage including femur fracture, tibia/fibula fracture, severed femoral artery. (R131) had external fixation device in place prior to open reduction and internal fixation (ORIF- surgical procedure used to treat bone fractures and dislocations by realigning broken bones stabilizing them with internal hardware) surgery to femur, fibula and tibia and a Stage 2 pressure injury to sacrum from decreased mobility. Surveyor reviewed R131's admission skin assessment documented on 8/6/2025:-Resident did not want to turn, admitted with a stage 2 pressure injury. On 8/6/2025 R131 care plan was initiated for potential/ actual impairment to skin integrity of the (specify location) r/t with the following interventions:- Assist to turn and/or reposition every 2-3 hours.- Educate resident/family/caregivers of causative factors and measures to prevent skin injury.- Encourage good nutrition and hydration in order to promote healthier skin.- Float heels if resident cannot turn and reposition themselves- Keep skin clean and dry. Lotion skin with cares. Do not apply lotion on (specify site of injury).- Monitor skin during cares. Report to nurse any changes.- Pressure reduction mattress.- The resident needs pressure reducing cushion to protect the skin while up in wheelchair.- Weekly licensed nurse skin evaluation. Surveyor noted the care plan did not specify the locations of impairment to R131's skin integrity. Surveyor reviewed R131's hospital discharge summary from 8/6/2025 and noted the following documented:-coccyx- pressure injury, wound care per Wound, Ostomy, and Continence Nurse (WOCN) recommendations. Surveyor reviewed R131's medication administration record and treatment administration record (MAR/ TAR) and physician orders and noted there was not an order to monitor or provide treatment to R131's coccyx/sacrum pressure injury. On 8/13/2025 Wound Nurse-EE documented the following assessment for R131's coccyx pressure injury. -Coccyx: pressure injury stage 3- 0.8cm X 0.4cm X 0.1cm (length X width X depth), 75% granulation, 25% slough- Surrounding skin excoriated On 8/19/2025 wound nurse-EE documented Coccyx pressure injury healed, 100% epithelialization. Surveyor noted that on 8/13/2025 Wound Nurse-EE stage R131's coccyx pressure injury as a stage 3 which would indicate the coccyx wound had a decline from a stage 2 to a stage 3. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted on R131's care plan was revised on 8/12/2025 with the following documentation:- The resident has potential/ actual impairment to the skin integrity of the left lower extremity (LLE), sacrum with the following revised interventions:- Keep skin clean and dry. Lotion skin with cares. Do not apply lotion on LLE, sacrum (revised 8/12/2025) Surveyor noted the following revisions to R131's care plan on 8/14/2025:-The resident has potential/actual impairment to skin integrity .Pressure wound to sacrum. Surveyor reviewed R131's treatment administration record (TAR) and noted an order that was started on 8/12/2025:- Cleanse sacral wound with wound cleanser and pat dry. Skin prep peri (around) wound. Cover wound with foam dressing every evening shift for wound care. Start 8/12/2024/ discontinued 8/14/2025.- 8/14/2025 New order to cleanse sacral wound with wound cleanser and pat dry. Skin prep Peri wound. Cover wound with foam dressing every evening shift every Tuesday, Thursday, and Saturday for wound care. Start: 8/14/2025. On 8/25/2025, at 12:35 PM, Surveyor interviewed Anonymous (Anon)-O who stated that R131 had wounds to the left leg. Anon-O was not aware if R131 had any pressure injury to the coccyx. Anon-O did not recall doing any treatments or monitoring of a pressure injury to R131's coccyx. On 8/26/2025, at 8:02 AM, Surveyor interviewed Wound Nurse-EE who stated 8/13/2025 was the first time Wound Nurse-EE hac seen R131's pressure injury to the coccyx. Wound Nurse-EE stated licensed nurses should do an assessment on admission or when an area of concern is noted and document the wound location, measurements, if there is drainage or odor present, how the wound bed looks and surrounding skin. Wound Nurse-EE stated that if they are in the facility, they will document the assessment and put in treatment orders, and revise the care plan, otherwise nursing should do it. Surveyor asked Wound Nurse-EE who puts in the orders for residents' treatments. Wound Nurse-EE stated that hospital paperwork will be reviewed and if there are orders or recommendations from the discharge paperwork, staff will need to call the physician to get an order in place. Surveyor asked Wound Nurse-EE how the measurements and staging was obtained on 8/13/2025. Wound Nurse-EE took the measurements and wound description/staging from Wound Nurse Practitioner (NP)-GG. Wound Nurse-EE stated they did not get a good look at R131's coccyx because Wound Nurse-EE was helping to hold R131 on the side so NP-GG could get measurements and assessments. Wound Nurse-EE was not aware of what the measurements or assessments of R131's coccyx pressure injury was while in the hospital or how R131's pressure injury was assessed/staged when admitted into the facility on 8/6/2025. On 8/26/2025, at 8:32 AM, Surveyor interviewed DON-B who stated R131 refused several times for R131's coccyx pressure injury to be assessed. Surveyor informed DON-B that there was no documentation noted that R131 was refusing to have R131's coccyx injury assessed, and nursing was not aware R131 had a pressure injury to the coccyx area. Surveyor asked DON-B how they knew R131's coccyx pressure injury was a stage 2 as documented in R131's admission progress note on 8/6/2025. DON-B could not recall how DON-B was made aware that R131 had a stage 2 pressure injury to R131's coccyx. Surveyor reviewed R131's progress notes and care plan and noted there were no indications that R131 had refused to have the coccyx wound assessed or that nursing had attempted to go back and assess R131's coccyx pressure injury after admission to the facility on 8/6/2025. On 8/26/2024, at 8:44 AM, Surveyor requested R131's hospital medical record for R131's wounds. (continued on next page)

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	09/30/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/2025, at 9:05 AM, Surveyor interviewed certified nursing assistant (CNA)-FF who could not recall if R131 had any pressure injuries. Surveyor asked CNA-FF how staff is made aware that a resident has a pressure area. CNA-FF stated that nursing makes staff aware, and it is usually on the resident's care card if they have any pressure areas or require interventions. Surveyor asked if R131 needed to be repositioned. CNA-FF stated R131 could move about in the bed, so CNA-FF helped R131 if R131 requested. CNA-FF stated R131 made R131's needs known. Surveyor asked CNA-FF if R131 was incontinent of urine and bowel. CNA-FF stated R131 used a urinal and bed pan. Surveyor asked CNA-FF if CNA-FF was ever made aware that nursing had to assess or wanted to assess R131's bottom for a pressure injury. CNA-FF replied CNA-FF was not made aware nursing wanted to look at or assess F131's bottom. CNA-FF stated that usually nursing will ask staff to notify them if they need to look at a resident during cares or shower so the resident does not have to turn a lot and can get done all at once. Surveyor reviewed R131's CNA care card that was last updated 8/20/2025 with the following interventions:Skin Integrity:- Assist to turn and/or reposition every 2-3 hours- Monitor skin changes during care. Report to nurse any changes. Surveyor noted that there is no indication on R131's CNA care card that R131 had a pressure injury to the coccyx. On 8/26/2025 Surveyor reviewed R131's skin assessments and noted the following skin assessment assessments that had been signed off by DON-B on 8/25/2025, at 13:15 (1:15 PM) documenting:- 8/7/2025- Attempted to roll for (DON-B) but could not at this time due to increased pain. Nurse informed to get a pain pill for (R131).- 8/8/2025- (R131) refused writer to assess wound at this time. (R131) was so tired. Surveyor notes that the above skin assessments on 8/7/2025 and 8/8/2025 were not initially in R131's medical record when Surveyor looked on 8/25/2025. On 8/26/2025, at 10:00 AM, Surveyor received R131's hospital records and noted the following documentation from Wound Ostomy Nurse Consult performed on 8/1/2025 while R131 was still admitted to [Hospital name]:page 193: …1. Wound care to coccyx for discharge: - Cleanse wound with soap and water- Apply Desitin topically- Assess and perform treatment daily and as needed. Page 195:Wound image and assessment dated [DATE]:-Stage 2 pressure injury, 2.0cm X 1.0cm X 0.1cm, small amount serous drainage, pink moist wound. Page 197:Impression dated 8/1/2025:-Coccyx, Hospital acquired- Stage 2 pressure injury, partial thickness skin loss- Etiology: Moisture, pressure, friction, shear.Measures to support wound healing:- Patient to remain on low air loss mattress- Reposition every 2 hours when in chair and bed- Offloading heel boots- Incontinence management- Barrier cream- Avoid use of briefs while in bed On 8/26/2025, at 3:55 PM, Surveyor shared concern with DON-B of concern that R131's pressure injury to R131's coccyx was not comprehensively assessed until 8/13/2025 and there was no monitoring or treatment in place until 8/12/2025 and was documented as a stage 3 pressure injury on 8/13/2025 which indicated a decline to R131's pressure injury to R131's coccyx. Surveyor requested to review NP-GG's documentation. (continued on next page)

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	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/2025, at 8:42AM, DON-B provided wound NP-GG's wound notes for R131 for 8/13/2025. Surveyor reviewed the wound notes and noted the following assessment documented: Pressure Ulcer- Coccyx- Pressure ulcer of sacral region, stage 2- There is minimum amount of yellow or brown exudate draining from ulcer. The ulcer is partial thickness with exposed dermis. The skin around the ulcer is blanchable, denuded, and excoriated. The ulcer is not malodourous. There are margins and islands of epithelialization. The ulcer border is well defined.- 0.8cm X 0.4cm X 0.1cmPlan of care:- Clean with wound cleanser- Apply foam border dressing 3 times per week for 1 month. Surveyor noted the assessment was electronically signed by wound NP-GG on 8/26/2025 at 6:02 PM. On 8/27/2025, at 10:19AM, Surveyor interviewed DON-B and asked when the facility receives NP-GG's assessments. DON-B stated that they will get the assessments from wound NP-GG the same day or the following day. Surveyor asked DON-B to see the initial wound assessment for R131's coccyx wound. DON-B replied that NP-GG was called last night to clarify if R131's coccyx wound was stage 2 or stage 3. DON-B stated that NP-GG spoke with the wound physician and clarified that R131's coccyx wound was stage 2 and not stage 3. Surveyor requested the original initial assessment that NP-GG filled out and wound NP-GG's phone number. Surveyor reviewed the original initial wound notes for R131's coccyx wound provided from wound NP-GG and noted the following documented:Pressure Ulcer- Coccyx- Pressure ulcer of sacral region, stage 3- There is minimum amount of yellow or brown exudate draining from ulcer. The ulcer bed has exposed subcutaneous tissue. This is full thickness ulcer. The skin around the ulcer is blanchable, denuded, and excoriated. The ulcer is malodorous. There are margins and islands of epithelialization. The ulcer border is well defined. There is over 50% granulation with a scattered pattern of pale quality. There is between 0 and 25% nonviable material of slough/fibrin quality.- 0.8cm X 0.4cm X 0.1cmPlan of care:- Clean with wound cleanser- Apply foam border dressing 3 times per week for 1 month. Surveyor noted the assessment was electronically signed by wound NP-GG on 8/13/2025 at 10:23 PM. On 8/27/2025, at 4:04PM, Surveyor interviewed NP-GG who stated the facility contacted wound NP-GG last night (8/26/2025) to clarify if R131's coccyx pressure wound was a stage 2 or a stage 3. NP-GG reviewed the documentation and picture and could not determine why R8's coccyx pressure injury was staged 3. NP-GG stated that the consulting physician was looped in to look at the assessment and picture for R131's coccyx pressure injury. NP-GG stated that they came to the conclusion that what NP-GG was interpreting as fatty tissue was actually dermis and that was indeed partial thickness, and not full thickness. Wound NP-GG confirmed that the consulting wound physician would not have staged R131's coccyx pressure injury at a stage 3 and that it in fact was a stage 2 on 8/13/2025. NP-GG stated that the following assessment on 8/19/2025 R131's coccyx pressure injury had healed. NP-GG confirmed with Surveyor that R131's coccyx pressure injury should have originally been documented as a stage 2 pressure injury on 8/13/2025. On 8/28/2025, at 8:00AM, Surveyor shared concern with nursing home administrator (NHA)-A that R131 did not have a comprehensive assessment on R131's coccyx pressure injury until 8/13/2025 and no monitoring or treatment was in place for R131's coccyx pressure injury until 8/12/2025. Surveyor shared with NHA-A that Surveyor spoke with wound NP-GG and clarified that R131 coccyx pressure injury did not decline to a stage 3 indicating there was not a decline to R131's coccyx pressure injury. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R50 was admitted to the facility on [DATE] with diagnoses that include chronic respiratory failure with tracheostomy, quadriplegia epilepsy, Gastrostomy feeding, stroke with hemiplegia and Metabolic encephalopathy. R50's admission Minimum Data Set (MDS) assessment dated [DATE] documents R50 is severely cognitively impaired. R50 is dependent for all cares, toileting and mobility. R50 is always incontinent of bowel and bladder. R50 is at risk for pressure injury. R50 has a stage 2 pressure injury present on admission. R50's Braden scale evaluation dated 6/16/25 documents a score of 13, indicating R50 is at moderate risk for pressure injury development. R50's skin integrity care plan initiated on 6/16/25 documents the following pertinent interventions: Assist to turn and/or reposition every 2-3 hours. Float heels if resident cannot turn and reposition themselves. Follow facility protocols for treatment of injury. Keep skin clean and dry. Pressure reduction air mattress. Weekly licensed nurse skin evaluation. Barrier cream to coccyx. Surveyor noted facility staff documented an intervention for barrier cream to coccyx, but the intervention did not include instructions of how often to use and when to use the cream. R50's admission initial wound assessment dated [DATE] documents, in part: Where was the wound acquired? Present upon admission… Coccyx pressure injury. Stage 2. Measurements: 3 cm x 2 cm x 0. 1 cm. 100% granulation. Surveyor noted facility staff documented a Stage 2 pressure injury with 100% granulation. According to the National Pressure Injury Advisory Panel (NPIAP) a stage 2 pressure injury is a partial-thickness skin loss with exposed dermis… Granulation tissue, slough and eschar are not present… A stage 3 pressure injury is a full thickness loss of skin in which adipose (fat) is visible in the ulcer and granulation tissue… [is] often present… https://cdn.ymaws.com/npiap. com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf Surveyor noted R50's pressure injury was staged incorrectly on R50's admission. R50 was admitted to the facility with a stage 3 pressure injury. R50's MD order with a start date of 6/19/25 documents: Cleanse coccyx wound with saline andpat dry. Apply Zinc oxide cream to area and leave open to air. Every shift for wound care. Surveyor noted a treatment for R50's coccyx wound was not started until three days after admission. Surveyor noted the treatment needs to be completed 3 times a day. Surveyor noted facility staff did not provide documentation that R50's pressure injury was treated each shift from 6/16/25 through 6/19/25. R50's Wound Nurse Practitioner (NP) note dated 6/25/25 documents, in part: Pressure Ulcer-Coccyx… Stage 3… This is a full thickness ulcer… There is 100% granulation with a confluent pattern of beefy red quality. Measurements were taken of a well-defined single wound on the coccyx. The ulcer measured 1.4 cm x 0.5 cm x 0.1 cm… Treatment: … cleanse the area with Wound cleanser… periwound skin treatment-Zinc Oxide 20%. Primary dressing- Zinc oxide 20%. This treatment will be done [every] shift and [as needed]… (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Even though the pressure injury was now identified as a Stage 3, instead of a Stage 2, Surveyor noted the treatment remained Zinc oxide every shift. Surveyor reviewed R50's Treatment Administration Record (TAR) and noted treatments were completed as ordered from 6/25/25 through 7/2/25. R50's Wound Nurse Practitioner (NP) note dated 7/2/25 documents, in part: Pressure Ulcer-Coccyx… Wound status-worsening. Measurements 2.2 cm x 2.5 cm x 0.1 cm. 100% granulation. Treatment: … cleanse the area with Wound cleanser… periwound skin treatment-Zinc Oxide 20%. Primary dressing-Zinc oxide 20%. This treatment will be done [every] shift and [as needed]… Surveyor noted R50's wound went from 1.4 x 0.5 x 0.1 measurements the week before to measurements of 2.2 x 2.5 x 0.1 one week later. The wound got significantly larger. Surveyor noted the treatment was not changed after the wound worsened. Surveyor noted the treatment remained Zinc oxide every shift. Surveyor reviewed R50's skin integrity care plan and noted facility staff did not add a new intervention to prevent the worsening of R50's pressure injury. R50's Wound Physician Assistant (PA) note dated 7/9/25, documents, in part: Pressure Ulcer-Coccyx… Measurements 1.8 x 1.6 x 0.1. Stage 3. 100% granulation. Treatment: … cleanse the area with wound cleanser. Primary dressing: collagen. Secondary dressing: bordered gauze… This treatment will be done daily by facility staff. Surveyor noted R50's treatment was changed and implemented by facility staff. R50's wound provider continued to visit R50 weekly for wound rounds. R50's pressure injury healed on 9/23/25. Surveyor reviewed R50's TAR and noted facility staff did not document that a treatment was completed on the following days: 7/4/25 night shift, 7/8/25 AM shift, 7/19/25 AM shift, 8/14/25 AM shift, 8/31/25 AM shift, 9/1/25 AM shift and 9/5/25 AM shift. On 9/29/25 at 11:22 AM, Surveyor observed R50's coccyx. R50 was rolled onto R50's right side. Surveyor observed Zinc oxide on R50's coccyx. Surveyor noted R50 does not have an active pressure injury. Surveyor noted 100% epithelial coverage on coccyx. On 9/29/25 at 9:10 AM, Surveyor interviewed Registered Nurse (RN)-QQ. Surveyor asked who completes admission skin assessments. RN-QQ stated the admission nurse. Surveyor asked what is included in the assessment. RN-QQ stated measurements and description of the wound. Surveyor asked if the nurse should stage the wound. RN-QQ stated staff are expected to stage the wound because they received training for that. Surveyor asked when treatment orders should be placed. RN-QQ indicated that after assessment, if the resident has a wound, the provider should be notified, and a treatment order should be entered. The treatment should be placed the same day of admission. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/25 at 2:25 PM, Surveyor interviewed the facility Wound Nurse (WN)-EE. Surveyor asked about the staging of R50's wound on admission. WN-EE stated that WN-EE was not sure if the person who assessed the wound on admission identified the correct stage. When WN-EE assessed the wound with the wound provider, the wound was a stage 3 pressure injury. Surveyor asked why R50's wound treatment was not changed when the wound worsened and R50 remained with just a treatment of Zinc oxide. WN-EE stated that WN-EE thinks the wound might have been a little moist and that is why it was not changed. Surveyor asked if Zinc is typically used on a stage 3 pressure injury. WN-EE stated that Zinc is typical for a stage 2 pressure injury. On 9/25/25 at 2:15 PM, Surveyor interviewed Nurse Practitioner (NP)-GG. NP-GG is a colleague of the Nurse Practitioner who documented and treated R50's wound at the beginning of R50's admission to the facility. Surveyor described facility documentation of R50's wound on admission. Surveyor asked if the wound was staged correctly. NP-GG stated that the wound was not staged correctly. NP-GG stated that a stage 2 wound is a partial thickness wound affecting the first 2 layers of skin. A stage 3 pressure injury gets into the subcutaneous tissue and is full thickness. Granulation tissue is not seen in a stage 2 pressure injury. R50 had a stage 3 pressure injury on admission. Surveyor asked if a treatment should be in place on admission. NP-GG stated yes. Surveyor reviewed R50's wound with NP-GG. Surveyor asked if Zinc oxide is an appropriate treatment for a stage 3 pressure injury. NP-GG stated all providers practice different. NP-GG stated, personally, I would not do Zinc on a stage 3 with granulation. Surveyor asked what NP-GG would do if a pressure injury doubled in size and is worsening. NP-GG indicated that coccyx wounds can be tricky. NP-GG stated R50 is dependent on staff for off loading the wound and is incontinent of bowel and bladder. Because of those reasons, NP-GG would have expected a change in treatment after a wound worsens. On 9/29/25 at 1:02 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked who completes the admission wound/skin assessment. DON-B stated that if the wound team is not in the building, the nurses are expected to complete the assessment. Surveyor asked if facility staff are expected to stage the wound. DON-B stated yes. Surveyor informed DON-B of the concern that R50's pressure injury was not staged correctly on admission. DON-B nodded DON-B's head up and down. Surveyor asked if a treatment should be placed right away after admission assessment. DON-B stated yes. Surveyor informed DON-B of the concern that R50's wound treatment order was not started until 3 days after admission. Surveyor asked what should be completed if a wound is documented as worsening and increases in size. DON-B stated that DON-B would expect the provider to look at a different treatment. Surveyor informed DON-B of the concern that R50's wound worsened and increased in size on 7/2/25 and the treatment order was not changed and R50's skin integrity care plan was not updated with a new intervention. Surveyor asked if facility staff should follow treatment orders and document the treatments as completed. DON-B stated yes. Surveyor asked where that documentation would be located. DON-B indicated the documentation is in the TAR. Surveyor informed DON-B of the concern that R50's treatments were not always documented as completed in R50's TAR. 3) R7 was admitted to the facility on [DATE] with diagnosis that include quadriplegia, dysphagia, traumatic subarachnoid hemorrhage with loss of consciousness, acute respiratory failure with hypoxia, chronic respiratory failure, Trach, anxiety disorder, schizophrenia, contracture, anemia. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent annual MDS (Minimum Data Set), dated 6/28/25 documents that R7 has severely impaired cognitive skills. R7 is rarely understood. R7 has impaired range of motion to both sides of his upper and lower extremities. R7 is noted to have significant contractures to both the right and left hand. R7 is at risk for pressure ulcer development and currently has an unhealed stage #3 pressure ulcer that was present on admission. A review of R7's individual plan of care, initiated on 5/25/22, documents that R7 has the potential for impaired skin integrity and/or development of pressure-related ulcer(s) and/or breakdown due to incontinence, thin, fragile skin, requires assist with skin care, chair fast and quadriplegic.Interventions included: *R7 will not develop any areas of pressure-related skin breakdown that is determined as avoidable. Initiated 5/25/22*Provide R7 with routine skin care at am/hs (morning/hour of sleep) care. Keep skin clean and dry. Apply lotion as needed. Assess skin with routine care for evidence of skin breakdown. Initiated 11/9/24. The Surveyor conducted a review of R7's Physician orders and noted that R7 has an order for a left resting hand splint that is to be on for 4 hours and off for 4 hours , every 4 hours. R7 also has a physician order for a right palm guard with carrot to be on every shift. Both orders were obtained on 8/5/24. In addition, on 8/28/24, a physician order was obtained to check R7's skin integrity with donning (placing on) and doffing (taking off) of contracture management device. If skin breakdown is identified, discontinue contracture management device order and initiate therapy referral. Document skin breakdown in Initial Wound Evaluation and Risk Management. Every 4 hours for left resting hand splint and right palm guard. The Nurse Practitioner Progress note, dated 3/20/25, indicates R7 was seen for the chief complaint of “ open area to thumb.” Pt (R7) was visited today as he rested in his wheelchair. His father was at bedside and alerted writer that pt had an open area to his thumb. Writer cleansed the area with normal saline, pat dry, apply TAO (triple antibiotic ointment), dry dressing, and placed a rolled towel in his hand for comfort. No s/s (signs/symptoms) of infection. Slight wheeze continues. No acute distress. Nursing denies s/s pain, cough, congestion, fever, chills, malaise, nausea, vomiting, diarrhea, or constipation. Nursing has no concerns at this time. Medical concerns addressed today: Open area to Left thumb: Cleanse with normal saline, pat dry, apply TAO, dry dressing, and rolled towel for comfort. Wound care to follow. The Surveyor conducted further medical record review and noted that the facility did not comprehensively assess the open area to R7's left thumb after it was addressed by the Nurse Practitioner on 3/20/25. There were no updates to the plan of care and no indication how the open area may have developed. It was also noted that there was no referral to therapy to further assess the use of the contracture management device (resting hand splint). There is no documentation if/when this area healed. On 6/13/25, the facility conducted a Braden Skin Assessment and noted that R7 is at high risk for pressure ulcer development. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing note dated 6/23/2025 at 2:16 PM stated, SBAR (situation, background, assessment and recommendation) Communication Evaluation Note Text: Situation: Open blister noted to Lt. inner thumb. Small amount blood bleeding noted no s/s of infection. Integumentary/Skin: New skin impairment Open blister Lt. inner thumb sm. amt. bleeding noted. Nurses observation of the resident: Sm. open blister to inner Lt. thumb sm. amt. bleeding noted. Cleansed with NS (normal saline) apply foam dressing. On 6/23/25, skin assessment indicates that R7 has an open blister to the left inner thumb, non-pressure. Measurements are 1 cm x 2 cm x 0.1 cm. The Nurse Practitioner Progress Note dated 6/23/2025 at11:00 PM documents; Chief Complaint-Open area to left inner thumb. General: The patient is a [AGE] year-old male with a PMH (past medical history) of respiratory failure who is trachea dependent. The patient (R7) is a total assist of 1 for ADLs and cares. The patient has severe contractures to both hands an

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	525281	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure that residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 4 of 12 (R60, R11, R41 and R90) residents reviewed for falls. R60 had a fall from bed while staff was providing cares which resulted in a laceration requiring sutures. The care plan was not revised with recommended interventions and staff were not educated following the fall. R11 had multiple falls. Observations found fall precaution interventions were not implemented and the facility did not complete thorough investigations of his falls. Following the falls, there was no evidence of an RN assessment. R41 had 6 falls while residing in the facility. The facility did not thoroughly investigate each fall to determine a root cause analysis to implement appropriate interventions to prevent further falls. R90 had a fall from bed. The facility did not thoroughly investigate the fall to determine a root cause analysis to implement appropriate interventions to prevent further falls. Findings include: The facility policy titled “Fall Prevention Program” dated 10/8/24 documents (in part) … .Each resident will be assessed for fall risk minimally upon admission, quarterly, annually and with change of condition and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 3. The nurse will acknowledge the resident's fall risk and initiate interventions on the resident's baseline care plan, with consideration of the resident's level of risk and individual needs. 4. The nurse will refer to the facility's Fall Care Plan template as a guide in determining potential initial interventions . 8. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored and reevaluated post fall as needed for effectiveness. b. The plan of care an Kardex will be revised as needed. 9. When any resident experiences a fall, the facility will: f. Review the resident's care plan and update as indicated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Document all evaluations/assessments and actions taken. h. Obtain witness statements to aide in root cause determination and injury review. i. Monitor residents' condition and response to interventions as per standard of practice. 1) R60 admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3, chronic obstructive pulmonary disease, morbid obesity, asthma, dysphagia, anxiety disorder, major depressive disorder, hypertension, gout, gastroesophageal reflux disease and hereditary and idiopathic neuropathy. R60's admission MDS (Minimum Data Set) dated 8/3/25 documents: functional limitation in range of motion lower extremity (hip, knee, ankle, foot) - impairment on both sides. Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed-partial/moderate assistance. R60's Admission/readmission/routine Head to Toe Evaluation dated 7/28/25 documents: Fall Risk evaluation-High risk. R60's BIMS (Brief Interview for Mental Status Score) dated 7/28/25 documents a score of 15, indicating no cognitive impairment. On 9/22/25 at 12:04 PM, Surveyor observed R60 lying in bed on her back, with the bed positioned against the wall on the left side. During initial interview, R60 reported she had a fall a few weeks ago. “The aid was rolling me over on my left side. I guess she forgot to lock the wheels on the bed because when she rolled me over and I put my hand on the wall to support myself, the bed moved and I rolled right out of bed onto the floor, landing on my face.” R60 pointed to her left eye, stating “I had 9 stitches. ” Surveyor observed a scar above her left eyebrow. Surveyor reviewed R60's care plan on 9/22/25 which documented: The resident has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) (blank) - date initiated 7/28/25. Intervention: Bed Mobility - the resident requires moderate assistance by 1 staff to turn and reposition in bed every 2-3 hours and as necessary - date initiated 7/28/25, revision on 8/19/25. The resident is at risk for falls, accidents and incidents r/t (blank) - date initiated 7/28/25. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance –date initiated 7/28/25. Facility progress notes documented: (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/1/25 at 6:28 PM, resident fell with CNA (Certified Nursing Assistant) in room while check and changing resident and she (CNA) unlocked bed to move bed with resident on side and she fell between bed and wall and gashed her head open above left eyebrow and sent out via hospital, family and NP (Nurse Practitioner) notified of occurrence. On 9/1/25 at 6:28 PM, called to room. Resident noted to be on the floor face down.stated CNA was in the room doing her (R60's) cares and when she was on her side (left side), she (R60) started moving away from the wall and the patient fell between the bed and the wall. Patient noted to have blood coming from the face. Face wiped clean and it was noted to be a laceration to the upper left brow 2 cm (centimeters) x 4 cm. Notably in pain and anxious. 911 called and writer stayed on the floor with patient until EMS (Emergency Medical Services) arrived. While waiting for EMS, ROM (Range of Motion) applied to all extremities with no new issues noted. Neuros initiated. DON (Director of Nursing), POA (Power of Attorney) and on call NP were notified of incident. Further intervention is to change patient from 1 assist with cares to a 2 assist with cares for safety and decrease risk for falls. EMS took her to ER (Emergency Room). On 9/1/25 at 10:26 PM hospital called and reported the CT (Computerized Tomography) negative. Stitches in place to left upper brow will be returning when transport becomes available. The hospital ED (Emergency Department) notes dated 9/1/25 document (in part) XXX[AGE] year-old female who presents to the ED with a fall. The patient was being cleaned up in her bed at her living facility, the bed started to roll, and she tried to turn and rolled out of bed. Hit her left forehead and left arm. Complains of pain in these areas. There is a large 4.5 cm laceration on the left forehead. X-rays negative for fractures. CT head negative for acute intracranial abnormality. Surveyor was provided R60's fall investigation which documented: Witnessed Fall with head injury 9/1/25 1850 (6:50 PM). Incident description: Nurse was called due to resident falling out of bed during a check and change. Resident stated she was getting changed by the CNA when the bed fell away from the wall, and she landed on the ground and hit her head. Resident was taken to hospital via ambulance due to hitting her head and getting a face laceration to forehead above the left eyebrow. Injuries observed at time of incident: No injuries observed at time of incident. Level of pain numerical: 10 LOC (Level of Consciousness): Alert, oriented to person, place. Notes: Resident fell out of bed during check and change and hit her head. Injuries report post incident: No injuries observed post incident. Predisposing environmental factors: Check mark other Predisposing situation factors: Check mark other (continued on next page)

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	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Other info: During check and change fell out of bed. 9/2/25 IDT (Interdisciplinary Team) met to discuss recent fall. Resident was receiving incontinence cares when she rolled out of bed. CNA was in providing cares per CP (Care Plan) of 1 assist. Resident was rolled in bed and kept rolling and rolled off the bed. CP reviewed and updated for assist of 2 when cares are provided. Fall investigation form signed by CNA-WW 9/1/25: Factors observed at the time of the fall: Circle all that apply: (circled) Environmental factors/other - (handwritten) “unlocked bed.” What could have been done differently to prevent this fall? Leave the bed locked. CNA-WW statement: I grabbed what I needed for cares. I was almost done with the resident. I helped her turn towards me, wheels locked on bed. (R60) then I needed to turn towards wall. The blankets were stuck between bed and wall when I turned the bed into the unlock position at that time (R60) slightly pushed against the wall the whole bed moved and (R60) fell slowly to the floor, smacking her head causing lac (laceration). Immediately went for help. On 9/10/25 at 7:00 AM, NP note/assessment: Currently in bed lying supine. Nine sutures present just above the left eyebrow that are clean, dry and intact. Some scabbing present. Skin pink. No swelling present. Sutures present for one week and are ok to remove per ER MD (Medical Doctor). Nine sutures successfully removed, and the patient tolerated well. No bleeding present. Area cleansed followed by TAO (triple antibiotic ointment). Surveyor noted on 9/22/25, there were no new interventions added to R60's care plan following the 9/1/25 fall. On 9/24/25 while reviewing R60's care plan, Surveyor noted the following revisions that were not present upon Surveyor's initial review of the care plan on 9/22/25: Bed Mobility: The resident requires moderate assistance by 2 staff to turn and reposition in bed every 2-3 hours and as necessary - date initiated 9/1/25, created on 7/28/25, revision on 9/22/25. Ensure Bed locks are engaged – date initiated 9/23/25. Surveyor noted these care plan revisions were added to R60's care plan after the start of survey on 9/22/25. On 9/23/25 at 10:25 AM, Surveyor asked CNA-FF where she would look to see how to care for a patient, for example how they transfer, continence, etcetera. CNA-FF reported they use the Kardex. Surveyor asked if staff has a paper copy to carry with them or is it in the residents' room. CNA-FF reported the Kardex is in the binder at the nurses' station and proceeded to show Surveyor a white binder containing residents' Kardex. Surveyor noted the resident Kardex in the binder were last updated on 5/13/25 and R60 did not have a Kardex in the binder. Surveyor asked CNA-FF if a resident does not have a Kardex what would you do and how would you know what is necessary to care for the resident? CNA-FF stated, “If they are a new admit, I'm old school - I would ask the nurse in report.” (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/25 at 12:59 PM, Surveyor spoke with DON-B with Nursing Home Administrator (NHA)-A present. Surveyor reviewed R60's fall investigation and asked what was done following R60's fall. DON-B stated, “We updated her care plan to be a 2 person with bed mobility and we did informal education with the CNAs on the unit to let them know she is now a 2 person.” Surveyor asked if any fall education was provided to any other staff after R60's fall. NHA-A stated, “Only the CNAs on the unit, and we updated her care plan.” Surveyor advised DON-B and NHA-A that R60's care plan was not revised to indicate 2-person bed mobility or the intervention to keep bed brakes locked until after the start of survey (interventions were added to care plan on 9/22/25 and 9/23/25). Surveyor asked and confirmed the fall investigation provided is the complete investigation. Surveyor advised the Kardex binder on the unit does not include a Kardex for R60 and in fact all other residents' Kardex had not been updated/were dated effective 5/13/25. 2) R11 was admitted to the facility on [DATE] with diagnoses of autistic disorder, repeated falls, unspecified intellectual disabilities, epilepsy, mood disorder, dementia, and anxiety. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired skills for daily decision making and both short and long term memory impairment. The MDS documents R11 does not have range of motion impairment. R11 requires substantial/maximum assistance for dressing and hygiene, supervision for transferring, eating and mobility. R11's Fall Care Area Assessment (CAA) completed 7/3/25 documents a fall CAA was triggered due to behaviors of wandering occurring daily, taking antianxiety, and antidepressant medications. The CAA documents R11 has ongoing use of psychotropic medications, weakness present that relies on staff for assist, rarely to never understood or understands. R11's Fall Risk Evaluation Document: - 7/3/25 score of 18 – in progress (not complete) - 7/31/25 score of 29 - 9/17/25 score of 27 A score of 10 or higher indicates the Resident is at high risk of falling. R11's Kardex dated 9/24/25 documents: - Allow resident to remain standing if R11 chooses - Antiroll back on wheelchair - Dycem in wheelchair to prevent slipping out - Encourage resident to keep hands free when up ambulating - Gripper socks or slippers with non skid bottoms at night. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Lock wheelchair after standing to prepare for sitting back down - Offer soothing music to assist resident with sleep hygiene - Resident to have a wedge cushion so R11 will not slip out while self propelling - Staff to ambulate resident to allow R11 to stretch R11 legs when R11 attempts to stand. - Staff to engage resident while propelling R11 in wheelchair either by holding hand or walking along side R11 R11's comprehensive care plan for Falls documents, The resident is at risk for falls, accidents, and incidents r/t (related to) SHUFFLING ON FEET OCCASIONALLY initiated on 7/5/25, revised 7/7/25. Interventions - Allow resident to remain standing if R11 chooses. Initiated 8/11/25. - Anticipate and meet the resident's needs. Initiated 7/22/25. - Antiroll back on wheelchair. Initiated 7/25/25 - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 7/5//25 - Dycem in wheelchair to prevent slipping out. Initiated 7/11/25. - Educated nurses on locking med (medication) cart wheels when med cart not in use. Initiated 8/11/25. - Encourage resident to keep hands free when up ambulating. Initiated 9/22/25. - Gripper socks or slippers with non-skid bottoms at night. Initiated 7/22/25. - Guardian updated to bring in sodas for resident to curb expressing self by putting self on the floor. Initiated 7/28/25. - Lock wheels after standing to prepare for sitting back down. Initiated 7/21/25. - Offer soothing music to assist resident with sleep hygiene. Initiated 7/31/25. - Resident to have a wedge cushion so R11 will not slip out while self-propelling. Initiated 7/12/25. - Staff to attempt to ambulate resident to allow R11 to stretch legs when R11 attempts to stand. Initiated 7/10/25. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff to engage resident while propelling R11 in wheelchair either by holding hand or walking along side R11. Initiated on 7/30/25. The resident has a behavior problem r/t (related to) intellectual disabilities (BITES, HITS, KICKS, THROWS ITEMS, PUTTING SELF ON FLOOR, AND PACES). Initiated 7/5/25, revision on 9/11/25. - I like to be approached forward, does not like people behind R11. Initiated 9/12/25. - I like to touch hair. Is very soothing to me. Please offer me the manikin head so that I can play with their hair instead of accidently pulling at staffs hair. Initiated 8/25/25. - If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Initiated 7/5/25. Revision on 9/11/25. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated 7/5/25. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Initiated 7/9/25 - Offer to hold residents hand for comfort. Initiated 7/22/25. - Praise any indication of the residents progress/improvement in behavior. Initiated 7/9/25. - Resident does not like fitted sheet on bed, only flat sheet and pillows. Initiated 8/7/25 - Resident enjoys to sit in dining room by window with blinds up to look out towards the water and have radio with R11. Initiated 7/22/25. - Resident likes to fidget with the cord to the radio and extension cord. Initiated 9/12/25 - Resident starts to tap fingers or feet when overstimulated. Allow resident time and offer a hand to hold. Initiated 7/9/25. - The resident enjoys calling and talking to sister (POA) [power of attorney]. Initiated 7/21/25 - The resident likes to touch their forehead to staff forehead for stimulation and calming (the resident initiates this only when reaching for your hand to touch their neck or when they reach their hand to staff's neck). Initiated 7/9/25 On 9/23/25, at 1:00 PM, Surveyor reviewed R11's 17 falls along with the facility's fall packets (investigations) of each fall from July 2025 to present (2025). (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 On 7/10/25, at 10:00 AM, R11 had a witnessed fall in the dining room while attempting to self ambulate. No injuries reported. All notifications completed. No Registered Nurse (RN) assessment completed. All staff statements collected and included in the packet. The root cause determined to be R11's poor safety awareness and attempts to self-ambulate. The care plan was updated and the intervention was initiated to have staff offer R11 to ambulate when R11 is attempting to stand up. 2 On 7/11/25, at 2:00 PM, R11 had a witnessed fall by the nurses' station while self-propelling in the wheelchair R11 scooted out of the wheelchair and onto the floor. No injuries reported. All notifications completed. No RN assessment completed. All staff statements included in the packet. The root cause determined to be R11 slid out of the wheelchair. The care plan was updated and the intervention of adding a dycem to the wheelchair. 3 On 7/12/25, at 1:34 PM LPN (Licensed Practical Nurse)-FFF documents a progress note that R11 had 2 witnessed falls. The first in R11's room at 11:00 AM and the second in the dining room at approximately 12:00 PM and it was witnessed by activity staff. No injuries noted and POA (power of attorney) made aware. There is not an investigation for this fall. The care plan was not reviewed and no updates to R11's care plan were made. 4 On 7/12/25, at 12:00 PM, R11 had a witnessed fall in the doorway of R11 room. R11 attempting to propel forward in R11 wheelchair and fell forward from R11 momentum. No injuries reported. All notifications completed. No RN assessment completed. 1 missing staff interview about the fall from CNA-DDD. The root cause determined to be R11 momentum carried R11 out of the wheelchair and on to the floor while self-propelling. The care plan was reviewed, and the intervention was added of placing a wedge cushion on the wheelchair Surveyor notes that of the two falls above for 7/12/25, the fall in the dining room was not investigated. 5 On 7/18/25, at 8:20 PM, R11 had a witnessed fall in the dining room. R11 was in the wheelchair reaching for R11's stereo and the wheelchair rolled back and R11 fell. No injuries reported. All notifications completed. No RN assessment completed. All staff statements included in the packet. The root cause determined to be the wheelchair rolled back as the resident attempted to stand and reach for the stereo. The care plan was reviewed and the intervention of anti-roll backs added to the wheelchair. 6 On 7/19/25, at 12:15 PM, R11 had a witnessed fall in the dining room. R11 was stood from the wheelchair, R11 fell before staff could reach R11. No Interdisciplinary note was made and there was no review of the care plan and no interventions implemented. 7 On 7/21/25, at 08:23 AM, R11 had a witnessed fall in R11's room. The fall was witnessed by R11's peer, but no interview of name of the peer was included in the fall investigation. All notifications completed. No RN assessment completed. The root cause was determined to be R11 fell when he attempted to sit in the chair in R11's room. The care plan was updated and the intervention of locking R11's wheelchair at bedside was placed. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8 On 7/22/25, at 10:15 AM, R11 had a witnessed fall in the dining room. All notifications completed. No RN assessment completed. The root cause was determined to be R11 was not an active participant in the activity and attempted to ambulate away. The care plan was reviewed and the intervention of keeping R11's radio near R11 at all times if he does not want to be an active participant in an activity was placed. 9 On 7/22/25, at 4:00 PM, R11 had an unwitnessed fall in R11's room. All notifications completed. A neurological assessment was completed. No RN assessment completed. The root cause was determined to be R11 may express R11's needs and wants by placing R11 on the floor. The care plan was reviewed and the intervention of providing sodas to R11 to make R11 happy was placed. 1 On 7/30/25, at 11:30 AM, R11 has a witnessed fall in the hallway. All notifications completed. No RN assessment completed. The root cause was determined to be R11 placed R11's feet down while being pushed in the wheelchair. The care plan was reviewed and updated with the intervention of having a second staff member walk along side of R11 or hold R11's hand while being pushed in the wheelchair. 1 On 7/31/25, at 3:05 AM, R11 had a witnessed fall in the hallway. All notifications completed. No RN assessment completed. The root cause was determined to be R11 was attempting to self-ambulate and fell. The care plan was reviewed and updated the intervention of offering soothing music at night to help with sleep was placed. On 8/10/25, at 2:25 AM, R11 had a witnessed fall by the nurses station on the unit. All notifications completed. No RN assessment completed. The root cause was determined to be R11 fell when trying to move past the med cart and the cart moved causing the fall. The care plan reviewed and updated, the intervention implemented was the staff was educated to keep nurses cart wheels locked. On 8/10/25, at 01:05 AM, R11 had a witnessed fall in the dining room. All notifications completed. RN assessment completed. The root cause was determined to be R11 fell when trying to stand when being asked to sit. The care plan was reviewed and updated and the intervention implemented was to allow R11 to stand if he chooses to do so 1 On 8/23/25, an emergency department note documents R11 had an unwitnessed fall and low oxygen status. It documents the facility staff are not sure what happened. There is no documentation that the facility completed a thorough investigation of this fall. On 9/12/25, at 10:50 PM, a progress note by LPN-GGG documents R11 had a fall at the doctor's office and received 2 sutures. A fall investigation was not completed. 1 On 9/17/25, at 6:45 AM, R11 had a witnessed fall in R11's room. All notifications completed. No RN assessment completed. The root cause was determined to be R11 fell when ambulating with both hands full. The care plan was reviewed and updated and the intervention implemented was to encourage R11 to have less items in hands so that R11 can stabilize or reach for assistance. 1 On 09/25/2025, at 12:54 PM, Surveyor observed R11 sitting in the hallway in a wheelchair. R11 has a table with R11's stereo in front. R11 was holding on to an extension cord and grabbing out at CNA-CCC. R11 then stood up, and CNA-CCC told R11 to sit down. R11 did not sit down and stepped toward CNA-CCC, Then R11 fell. R11 did not hit head. R11's wheelchair was not locked. LPN-ZZ told Unit manager (UM)-F to go and get an RN. LPN ZZ trying to get vitals signs. The RN-QQ responded and assessed. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/24, at approximately 1:00 PM, LPN-ZZ documented in a progress note R11 had a witnessed fall in the hallway. R11 attempted to stand and walk without assistance, when reaching for R11's designated CNA-CCC, R11 fell. All notifications completed. RN QQ documented “Staff came to report R11 on [Unit R11 resides] had a fall and they needed writer to come assess R11. R11 had put self back in w/c (wheelchair) MAEW (Moves All Extremities Well) no apparent injury” as the assessment for R11's fall. All notifications completed. R11 was on direct (1:1) supervision by CNA-CCC and will continue to be directly supervised. Surveyor noted CNA-CCC did not attempt to ambulate R11 and did not lock R11's wheelchair per care plan. Surveyor made the following observations of R11's care plan not being implemented: 1.Dycem and wedge cushion not in wheelchair 9/22/25 at 1:02 PM 9/23/25, at 7:24 AM 9/23/25 at 10:38 AM 9/24/25 at 7:06 AM On 9/24/25, at 9:50 AM, Surveyor observed the Kardex for R11 at the nurses station. The last update to the Kardex is documented as 7/30/25. The dycem and wedge cushion is included in the current Kardex. On 9/24/25, at 9:52 AM, Surveyor interviewed CNA-DDD about R11's dycem and wedge cushion in the wheelchair. CNA-DDD stated R11 must have removed it and it is usually left in the chair. LPN-ZZ states LPN-ZZ will call laundry to see if it was sent there to be cleaned. On 9/24/25, at 9:53 AM, Surveyor conducted observed R11's room and did not see a wedge cushion or dycem. 2. Medication cart wheels unlocked 9/22/25 at 1:04 PM 9/23/25 7:21 AM and 10:38 AM 9/25/25, at 7:45 AM and at 10:22 AM (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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	525281	A. Building B. Wing	09/30/2025

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	525281	A. Building B. Wing	09/30/2025

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 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility did not provide appropriate treatment and services for 1 (R89) of 1 resident with a diagnosis of dementia with behavioral symptoms to allow them to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.R89 has a diagnosis of Unspecified Dementia, Unspecified Severity with Agitation, Depression, Anxiety Disorder and Visual Hallucinations. On 6/4/25, R89 triggered on the trauma assessment as having experienced physical assault, however, there is no care plan with person centered interventions for staff to work with R89. There was no comprehensive assessment with individualized interventions of R89's behaviors, the facility did not assess the behavior change to identify the root/cause of R89's behavior. The facility did not complete a dementia assessment. The Treatment Administration Records (TARS) do not document any behavior accurately for R89. There is no comprehensive assessment with individualized interventions of R89's behaviors, the facility did not assess the behaviors to identify the cause of R1s's behavior, and the care plan was not revised as person centered. On 8/3/25, the facility updated R89's care plan to reflect that R89 was to receive 1:1 supervision, however, the 1:1 supervision was to be expected from staff on shift and not an actual single staff supervising only R89. R89 did not have a comprehensive assessment identifying specific behaviors along with non-pharmalogical interventions, an individualized plan of care to address behaviors effecting others including physical, sexual, and verbal abuse including verbally threatening to other residents on the dementia unit.Findings include:R89 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity with agitation, depression, anxiety disorder, visual hallucinations and essential hypertension. R89 currently has a legal guardian.R89's Quarterly Minimum Data Set(MDS) completed 5/19/25 documents R89's Brief Interview for Mental Status(BIMS) score to be 0 indicating R89 demonstrates severely impaired skills for daily decision making. R89's MDS documents R89's Patient Health Questionnaire(PHQ-9) score to be 0. R89's MDS documents R89 demonstrated rejection of care 1-3 days. R89's MDS also documents R89 has no range of motion(ROM) impairment. R89 requires substantial/maximum assistance for eating, upper and lower dressing, mobility, and transfers. R89 is dependent assistance for showers.R89's care card instructing nursing staff in the care of R89 as of 8/25/25 documents:-R89 requires stand by 1 staff to move between surfaces as necessary-R89 is independent by 1 staff to turn and reminders to reposition in bed-R89 requires minimum assistance by 1 staff to dress-R89 requires minimum assistance by 1 staff with bathing/showering each shift and as necessaryR89's applicable comprehensive care plan includes the following:Problem: R89 has impaired cognitive function/dementia or impaired though processed due to dementia Initiated 2/24/25 Revised 5/14/25Intervention: Correct R89 when using incorrect words to promote word finding Initiated 7/22/25Problem: R89 has sleep deprivation due to dementia. Initiated 4/9/25Interventions:--Assess for underlying physiological illnesses causing sleep loss, assess for level of agitation. Initiated 4/9/25--Keep environment quiet for sleeping. Initiated 4/9/25--Obtain a sleep wake history Initiated 4/9/25Problem: R89 is an elopement risk/wanderer due to disoriented to place, impaired safety awareness, R89 wanders aimlessly, significantly intrudes on the privacy or activities Initiated 6/5/25Problem: R89 has experience trauma due to (not complete/left blank) Triggers that have potential to re-traumatize me (not complete/left blank). Once I experience a trigger, I may display these signs/symptoms: anxiety/edginess, overwhelming, anger/irritability, changes in mood state, nightmares, change in sleep pattern, confusion/disorientation, pain/achiness, muscle tension, extreme alertness/hypervigilance, withdrawal/avoidance of activites, other Initiated 2/24/25 Revised 5/14/25Problem: R89 is at risk for substance abuse related to historical use of alcohol and recreational drugs Initiated 7/28/25Problem: R89 is at risk for mood impairment due to depression and anxiety Initiated 2/13/25Interventions:--Monitor/document/report as needed any risk for harm to self:suicidal plan, past attempt at suicide, risky actions, intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Initiated 2/13/25--Monitor/record/report to MD as needed mood patterns signs of symptoms depression, anxiety, sad mood as per facility behavior monitoring protocols. Initiated 2/13/25Problem: R89 has behavior problems refusing cares, combative, yelling, grabbing, and displaying loving affection towards females. R89 has hallucinations. Initiated 2/13/25 Revised 7/11/25Interventions:--Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to

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	525281	A. Building B. Wing	09/30/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that irregularities noted by the pharmacist during the Medication Regimen Review (MRR) were sent to the attending physician to include at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified for 2 of 5 (R11 and R60) residents reviewed for unnecessary medications. R11's pharmacy MRR recommendations for July and September 2025 were not acted upon by the facility or physician. R60's pharmacy MRR recommendations for August 2025 were not acted upon by the facility or physician. Findings include: 1.) R60 admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3, chronic obstructive pulmonary disease, morbid obesity, asthma, dysphagia, anxiety disorder, major depressive disorder, hypertension, gout, gastroesophageal reflux disease and hereditary and idiopathic neuropathy. The facility policy titled “Addressing Medication Regimen Review Irregularities (Pharmacist Recommendations) dated 11/11/24 documents (in part) … …It is the policy of this facility to provide a Medication Regimen Review for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event. 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon. b. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form. d. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. Surveyor review of R60's MAR (Medication Administration Record) documented an order for Alprazolam Oral Tablet 0.25 MG (milligrams) give 1 tablet by mouth every 8 hours as needed for anxiety - start date 8/12/25. Facility progress note dated 8/22/25 at 12:58 PM, documented: Pharmacist reviewed/recommendation made/see separate report. The Pharmacy “Note to Attending Physician/Prescriber” printed 8/24/25 documents: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current order: Alprazolam PRN OD (ordered) 8/12/25 without stop date. Resident with 10x (times) use since started. CMS F758 phase 2 implementation requires PRN psychotropic orders to be written for no more than 14 days. If PRN psychotropic orders are deemed necessary beyond this time, clinical rationale and a specific duration need to be provided by the prescriber. Recommendation: Please discontinue or provide rationale for continued PRN Alprazolam use for facility documentation. Surveyor noted options to check the following: Discontinue PRN Alprazolam Continue PRN Alprazolam as the benefits outweigh the risks. Reassess in (line blank) months. Surveyor noted neither recommendation/option was checked. Physician/Prescriber Response: Resident continues to take Alprazolam PRN daily. Schedule Alprazolam daily. Signed by NP (Nurse Practitioner) 9/23/25. Surveyor noted the physician response to the pharmacy recommendations on 8/22/25 was dated 9/23/25, after Surveyor asked for information. On 9/25/25 at 2:50 PM, Surveyor asked Director of Nursing (DON)-B what the process is and who is responsible for following up on pharmacy recommendations. DON-B reported the pharmacy sends her an email and then she notifies the NP or doctor. Surveyor advised DON-B of concern there was no follow up on R60's pharmacy recommendations from 8/22/25. 2.) R11 was admitted to the facility on [DATE] with diagnoses of Autistic Disorder (affects how people interact with others, communicate, learn, and behave.), Repeated Falls, Unspecified Intellectual Disabilities (individual exhibits significant limitations in both intellectual functioning and adaptive behavior), Epilepsy (chronic neurological condition characterized by recurrent seizures, which are episodes of shaking and convulsions), Mood [Affective] Disorder (persistent and significant changes in mood, emotions, and behavior), Anxiety Disorder (excessive worry, fear, and nervousness that can interfere with daily life) and Gastrostomy (surgical procedure that creates an opening in the stomach through the abdominal wall to allow for feeding and medication administration directly into stomach). R11 currently has a legal guardian. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired cognitive skills for daily decision making and has short and long term memory deficits. R11's Patient Health Questionnaire (PHQ)-9 score is documented as 14 indicating R11 demonstrates moderate depressive symptoms. R11 demonstrates physical behaviors that significantly interferes with resident care, participation in activities, intrudes on privacy or activity of others, disrupts care of living environment. R11's MDS also documents that R11 demonstrates rejection of care and wandering daily. R11's has no range of motion impairment. R11 requires supervision for eating (at time of MDS, R11 was nothing by mouth (NPO), dependent for showers. R11's MDS requires partial/moderate assistance for upper dressing and substantial/maximum for lower body dressing. R11 is independent for mobility and transfers. Surveyor reviewed R11's current physician orders and R11's pharmacy reviews. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's facility progress note written by Consultant Pharmacist (CP)-NNN on 7/17/25, at 2:02 PM, documented: …”Pharmacist reviewed/recommendation made/see separate report. ”… 1.The Pharmacy “Note to Attending Physician/Prescriber” printed 7/18/25 and documented by CP-NNN: Lorazepam as needed(PRN) + Temazepam PRN since admit 7/3/25 Current order: CMS F758 phase 2 implementation requires PRN psychotropic orders to be written for no more than 14 days. If PRN psychotropic orders are deemed necessary beyond this time, clinical rationale and a specific duration need to be provided by the prescriber. Recommendation: Please discontinue or provide rationale for continued PRN Lorazepam + Temazepam use for facility documentation. Surveyor noted options to check the following: -Discontinue PRN Lorazepam -Continue PRN Lorazepam as the benefits outweigh the risks. Reassess in (line blank) months. AND -Discontinue PRN Temazepam -Continue PRN Temazepam as the benefits outweigh the risks. Reassess in (line blank) months. Surveyor noted neither recommendation/option was checked for both. A handwritten note with no signature on the form documents:…”8/5 Lorazepam changed to scheduled No change to Temazepam”… 2.The Pharmacy “Note to Attending Physician/Prescriber” printed 7/18/25 and documented by CP-NNN: Current Order: Duplicate Olanzapine 15 mg QHS agitation + high dose Quetiapine 400 mg 3 times a day Autism with behavior and agitation(manufacturer max dose=800 mg/day). CMS requires review of antipsychotics for Gradual Dose Reduction(GDR) within 2 weeks of admission. Antipsychotics are high risk list medications due to increased mortality from stroke, metabolic disorders and falls from sedation, movement disorders and orthostatic hypotension. Resident also on Buspar 30 mg twice daily anxiety + Lorazepam 1 mg q4h PRN agitation + Amitriptyline 50 mg qhs sleep + Temazepam 30 mg qhs PRN sleep 7/3/25. Also, on Depakote 625 mg three times daily + Oxcarbazepine 600mg twice daily for seizures which may also be helpful for mood and behaviors. Recommendation: Please consider a trial dose reduction to assess continued need for treatment and check one of the following: (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medication to be continued as ordered. Discontinuation of therapy likely will be harmful to resident and/or others, or it will interfere significantly with the provision of care for others. -Reduce the current order to Quetiapine 400 mg three times daily due to max per manufacturer and continued 15 mg qhs. Surveyor noted neither recommendation/option was checked for both. A handwritten note with no signature on the form documents:…”Olanzapine addressed on 7/18 Rept Quetiapine continued as is”… R11's facility progress note dated 9/25/25, at 1:37 PM, documented: …”Pharmacist reviewed/recommendation made/see separate report.”… 3.The Pharmacy “Note to Attending Physician/Prescriber” printed 9/25/25 and documented by CP-NNN: Current Order: Please clarify the following order from admission 9/12/25 for potential transcription error and potential risk for falls 1.Valproate 250 mg/5ml-give 5ml peg tube three times daily for seizure 625 mg three times daily. Please note 7.5v ml=375 mg not 625 mg. Resident was on 625 mg three times daily prior to readmit and discharge summary 9/12 notes 625am/625noon/625evening -Please notify prescriber resident was taking 5 mg(250 mg) 9/12 and then 7.5(375 mg) 9/20. Does of 625 mg=12.5 ml. 2.Lorazepam 1 mg q4h scheduled 00,4,8,12,16,20. Resident was on PRN prior 8/5/25. Scheduled 6 times a day may be viewed as chemical restraint since lowest possible dose not used. Please consider change back to PRN. 3.Olanzapine 30 mg qhs. Resident on 15 mg twice daily(increased from 15 mg qhs 7/18/25 prior readmit. -Should order be divided and given 15 mg twice daily or cx 30 mg qhs. 4.Temazepam 30 mg qhs insomnia 9/12/25. Resident on PRN prior admit. Discharge summary 9/12/25 notes PRN. Temazepam with 0 use prior admit to hospital and now scheduled. -Please clarify Temazepam order and if it should be PRN or scheduled. Surveyor noted neither recommendation/option was checked for the three. A handwritten note with no signature on the form documents:…”reviewed with MD 9/28/25 via phone.”… (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/28/25, at 10:45 AM, Nursing Home Administrator (NHA)-A documented:…”Writer reviewed resident's medication since admission with MD. Amlodipine should remain discontinued due to blood pressures obtained at facility with some hypotensive results noted. Temazepam should remain scheduled instead of PRN to assist him with sleeping at night. Valproic acid was increased to the 625 mg level with follow-up for possible drug level check in a few weeks. Seroquel returned to 400 mg three times daily due to noted increases in expressions. On 9/25/25, at 2:50 PM, Surveyors interviewed Director of Nursing (DON)-B in regard to what the process is and who is responsible for following up on pharmacy recommendations. DON-B reported the pharmacy sends DON-B an email and then DON-B notifies the Nurse Practitioner or Physician. On 9/29/2025, at 2:44 PM, Surveyor shared with DON-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the concern that R11's pharmacy reports were not being acknowledged by the physician with the recommendations as well as to discontinue or keep the medication orders the same. No further information has been provided by the facility at this time.

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	525281	A. Building B. Wing	09/30/2025

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure therapy services were provided in a timely manner for 2 (R11 and R50) of 2 residents reviewed for therapy services. *R11 has a MD order to start therapy services initiated on 9/11/25. R11 did not have a therapy evaluation until 9/22/25. *R50 was admitted to the facility on [DATE]. On 6/20/25, R50's MD documented that R50 should have a Physical (PT) and Occupational therapy (OT) evaluation and treatment. R50 was not evaluated and treated by PT and OT until 7/11/25. Findings include: The facility policy with a reviewed/revised date of 11/12/24 and titled, “Therapy Evaluation”, documents, in part: The licensed Therapist will perform an initial resident evaluation upon physician referral and re-evaluation where indicated . The rehabilitation department will be notified when a physician order is written for therapy evaluation and treatment. The licensed therapist will perform a chart review and initiate the evaluation. The initial evaluation will include, but is not limited to, the following: Resident name, date of birth , and health insurance or ID number. Diagnosis (treatment diagnosis and medical diagnosis). Past medical history. Prior level of function. Current functional level, including illness severity or complexity, as well as cognitive status. Rehabilitation potential/severity. Short- and long-term goals and time frames for completion. Treatment plan of care to accomplish goals. Resident's social support network and discharge plan. Initial evaluation will be completed as per facility policy. Evaluations will be documented, signed by licensed therapist, printed/uploaded, and placed in the resident's chart. Completed evaluation will be signed by the physician. *R50 was admitted to the facility on [DATE] with diagnoses that include Chronic respiratory failure with tracheostomy (a tube inserted into an airway to facilitate breathing), Quadriplegia (loss of motor function in all four limbs), Epilepsy (seizure disorder), Gastrostomy (feeding tube inserted into stomach to provide nutrition and medications), Stroke with hemiplegia (one sided weakness) and Metabolic encephalopathy (impaired brain function due to a systemic problem). R50's admission Minimum Data Set (MDS) assessment dated [DATE] documents R50 is severely cognitively impaired. R50 is dependent for all cares, toileting and mobility. R50's MD order initiated on 6/16/25 documents: PT/OT/ [speech therapy]/ [respiratory therapy] to evaluation and treat as indicated. R50's admission History and Physical (H&P) completed by Medical Director (MD)-J and dated 6/20/25 documents, in part… The medical problems that were addressed today: Brain tumor glioblastoma [status post] chemotherapy, radiation and craniectomy. G-tube dependent, trach dependent, nonverbal, quadriplegic, bedridden: PT OT to eval and treat… Surveyor reviewed R50's PT and OT evaluation and visit notes and noted that R50 started PT and OT on 7/11/25. Surveyor noted R50 did not start PT/OT for over 3 weeks after admission. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/29/25 at 2:57 PM, Surveyor interviewed MD-J. Surveyor asked if MD-J wanted R50 to participate in PT and OT after admission as documented in MD-J‘s H&P. MD-J stated absolutely. Surveyor informed MD-J that R50 did not start PT/OT until over 3 weeks of admission. Surveyor asked if R50 should have been evaluated sooner. MD-J stated R50 absolutely should have started closer to admission. MD-J stated that R50 is a critical and complicated medical case and would benefit from therapies at least weekly after admission. R50's Physician progress note dated 6/26/25 at 11:03 AM, documents, in part: … Continue to monitor for any increase in tone. Continue PT to improve strength, balance and coordination related to hemiplegia and deficits in proprioception… Surveyor noted R50's provider thought R50 was in PT when R50's progress note was written on 6/26/25. Surveyor noted R50 was not participating in PT/OT services on 6/26/25. On 9/29/25, Surveyor was given a one-page paper document form, “Screening tool” dated 6/17/25. R50's name is on the paper form. The following is documented on the form, in part: Purpose-Admit. Wheelchair, Mobility, [Activities of daily living], Bathing, Feeding, Toileting: Dependent. Diet: Tube fed… Recommendations: No eval. Comments: Baseline… On 9/29/25 at 10:20 AM, Surveyor interviewed Therapy Director (TD)-VV. TD-VV stated that TD-VV started this position on September 8th. Surveyor asked about the R50's paper document screening tool. TD-VV stated that this form was from the last therapy director. TD-VV stated that TD-VV had not seen this form and was searching for any documentation about R50's therapy evaluation on admission. TD-VV asked Surveyor for a copy of the form. Surveyor asked if this form is typically used. TD-VV stated that evaluations and screening should be entered into the computer and is not a paper document. Surveyor asked how long it takes for a newly admitted resident to be seen by therapy. TD-VV stated that typically a resident who was just admitted and has a MD order or consult for therapy will be evaluated within 3 days of admission. Surveyor showed TD-VV R50's admission H&P and MD order. Surveyor asked why R50 did not start treatment therapies until 7/11/25. TD-VV stated that R50 should have had a full evaluation closer to admission. Surveyor asked if the paper documentation is a full evaluation. TD-VV stated no and indicated that R50 should have had a more thorough evaluation than what is listed on the paper form. Surveyor asked if there was a change that R50 experienced that led to R50 being evaluated on 7/11/25 instead of closer to admission. TD-VV stated that TD-VV was not aware and did not know if anything changed but TD-VV knows that R50 should have been more thoroughly evaluated sooner. On 10/1/25 at 1:45, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R50 was admitted on [DATE]. R50 had a MD order, and documentation in R50's admission H&P that R50 should be evaluated and treated by PT and OT. R50 did not start receiving therapy services until 7/11/25. (continued on next page)

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	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R11 was admitted to the facility on [DATE] with diagnoses of Autistic Disorder (affects how people interact with others, communicate, learn, and behave.), Repeated Falls, Unspecified Intellectual Disabilities (individual exhibits significant limitations in both intellectual functioning and adaptive behavior), Epilepsy (chronic neurological condition characterized by recurrent seizures, which are episodes of shaking and convulsions), Mood [Affective] Disorder (persistent and significant changes in mood, emotions, and behavior), Anxiety Disorder (excessive worry, fear, and nervousness that can interfere with daily life) and Gastrostomy (surgical procedure that creates an opening in the stomach through the abdominal wall to allow for feeding and medication administration directly into stomach). R11 currently has a legal guardian. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired cognitive skills for daily decision making and has short and long term memory deficits. R11's Patient Health Questionnaire (PHQ)-9 score is documented as 14 indicating R11 demonstrates moderate depressive symptoms. R11 demonstrates physical behaviors that significantly interferes with resident care, participation in activities, intrudes on privacy or activity of others, disrupts care of living environment. R11's MDS also documents that R11 demonstrates rejection of care and wandering daily. R11's has no range of motion impairment. R11 requires supervision for eating (at time of MDS, R11 was nothing by mouth (NPO), dependent for showers. R11's MDS requires partial/moderate assistance for upper dressing and substantial/maximum for lower body dressing. R11 is independent for mobility and transfers. R11's current physician orders document: PT(physical therapy)/OT (occupational therapy)/ST (speech therapy)/RT (respiratory therapy) to evaluate and treat as indicated with an order date of 9/11/25. Speech Therapist (ST)-PPP documented a screen was completed on 9/11/25. ST-PPP documents due to severity of disability and recommended nothing by mouth (NPO), no treatment indicated at this time. An unsigned therapy screen completed 9/22/25 documents R11 would not benefit from skilled therapy services as R11 is currently at baseline with functional mobility. R11 has demonstrated aggressive behaviors, limiting R11's participation and proving unsafe for therapy. Surveyor notes that therapy disciplines did not attempt to screen R11 again for rehabilitation services and relied only on previous documentation of therapy disciplines. On 9/24/2025, at 12:48 PM, Surveyor interviewed Rehabilitation Director (Therapy Director)-VV. Therapy Director-VV stated a screen and/or evaluation should be completed within three days of a physician order. Therapy Director-VV stated the screen should be completed first and then the continued evaluations. Therapy Director-VV stated that R11 has been at baseline and nursing reports no changes. (continued on next page)

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/2025, at 2:57 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the concern that R11 was readmitted to the facility on [DATE] and current physician orders document a PT, ST, and OT evaluation was ordered on 9/11/25. A screen was not completed until 9/22/25, 11 days later for OT and PT, and a ST screen was completed on 9/11/25. Surveyor shared that OT, PT, and ST screens were completed based on documentation only and not actually physically re-assessing after re-admission to the facility after a lengthy hospitalization. Surveyor shared given the number of falls R11 continues to have, it is concerning that OT and PT have not been involved with new interventions to prevent R11 from falling. No further information has been provided by the facility at this time as to why there was a delay in completing therapy screens. On 9/29/2025, at 10:25 AM, Therapy Director-VV stated that typically there should not be a delay. Therapy Director-VV does not know who ordered therapy services on 9/11/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Based on interview and record review, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The administration was not promoting the highest practicable mental and psychosocial well-being of residents by failing to implement procedures based on the facility Abuse, Neglect, and Exploitation policy and procedure last revised 7/12/25. Multiple staff were aware R89 and R106 were unpredictable. R89 had multiple resident-to-resident altercations, as well as punching staff in the face and was sexually inappropriate to staff and residents. Staff informed administration of R89's physical aggression and sexual behaviors to administration. Staff warned administration that R106 was escalating in behaviors towards R121. Furthermore, as Surveyor attempted to investigate the abuse allegations, the facility attempted to intimidate staff to limit the information shared with State Agency staff as well as not maintain accurate documentation of staff statements in regard to allegations of abuse. Staff who have reported abuse on the dementia unit have been terminated by the facility and suspended during the survey process. This deficient practice has the potential to affect all 30 residents residing on the dementia unit within the facility at the time of the survey.During a complaint survey conducted on 8/25/2025-9/2/2025, it was determined 11 deficiencies existed including the deficient practice at F835 (Administration). Each of the deficiencies identified systemic issues within the facility that were not addressed by facility administration through established processes. Three of the deficiencies have been identified to be deficient at a severity level of immediate jeopardy at a scope of pattern. Additionally, systemic concerns were identified with the environment, including pest control, reporting of abuse allegations, treatment/services for dementia, specialized services, quality of care, and treatment/services for pressure injuries.*On 4/19/25, an allegation of resident-to-resident altercation involving R89 and R122 was reported immediately to Nursing Home Administrator (NHA)-A. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*On 6/4/25, R89 was observed in R110's room, a female resident with a history of sexual assault was inappropriately sexually touched by R89. R89 was on R89's knees at R110's bedside. R110's brief was off, was not covered with a sheet or blanket, and R89 was observed with R89's hand on R110's vaginal area. The allegation of inappropriate sexual contact was not reported to the State Survey Agency within 2 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*On 8/10/25, R89 was observed to have R89's hand under R110's shirt. The allegation of inappropriate sexual contact was not reported to the State Survey Agency within 2 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*On 4/19/25, R89 was observed punching R122 in the face in which R122 sustained a skin tear to the left cheek. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*On 6/28/25, R89 was observed verbally abusing and physically threatening R39. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*On 3/17/25, R106 was observed repeatedly hitting R121 with a pillow. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*On 4/30/25, R106 was heard to physically threaten R121 by stating R106 wanted to cause bodily harm and cause bleeding. The allegation of resident-to-resident altercation was not reported to the State Survey Agency within 24 hours and was not thoroughly investigated. (Cross reference F600, F607 F609, F610)*Staff are in fear of retaliation and do not know what to report to administration.The administration's failure to review what happened with R110,R26, R121, R57, R122, and R39, its failure to implement procedures to ensure that vulnerable residents were protected from abuse or further potential abuse, its failure to follow the policy and procedure to ensure staff was free from retaliation, its failure to develop a plan for monitoring R89 and R106 and ensuring the safety of all residents on the dementia unit, and its failure to ensure all staff were not intimidated by administration, not feeling able to freely speak to Surveyor staff or there would be negative consequences up to losing their jobs, created a finding of Immediate Jeopardy (IJ) beginning on 3/17/25.On 9/2/25, at 4:28 PM, Nursing Home Administrator (NHA)-A, and Director of Nursing (DON)-B were informed of the Immediate Jeopardy. The Immediate Jeopardy was removed on 10/30/25. The deficient practice continues at a scope and severity (S/S) of an F (potential for

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an effective pest control program to address the flies in the facility.*) R13 informed Surveyor that the facility has a problem with flies and has a fly swatter by the bed to keep flies away. Surveyor observed flies by R13's bedroom window.*) R26 had flies in R26's room during an interview with Surveyor and were landing on R26's hat.*) R75 informed that the flies in the facility are bad, especially when food is out.*) R107 informed Surveyor that flies are around in the room and hallways especially when food is not picked up right away or garbage's are not emptied.*) Surveyors observed flies in resident rooms, resident unit hallways, and hallway by the facility kitchen.This deficient practice has the potential to affect all 103 of 103 resident residing in the facility at the time of the survey. Findings include:The facility policy titled Pest Control Program implemented on 4/2/2025 documents: It is the guideline of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.4. Facility will utilize a variety of methods in controlling certain seasonal pests, i. e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations.5. Facility will ensure that the outside pest service also treats the exterior perimeter of the facility and any outlying buildings or structures, i.e. dumpster area, etc.*) R13 was admitted to the facility on [DATE]. R13's admission Minimum Data Set (MDS) assessment dated [DATE] documents R13 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R13 has intact cognition.On 9/2/2025, at 9:30AM, Surveyor interviewed R13 who stated that flies are bad in the facility, has been good couple days and not swarming but usually one or two flies daily. Surveyor observed a fly swatter on R13 bedside table. R13 stated that R13 will swat flies away with it. R13 stated that when food trays come is usually when flies are around or when R13 is having a wound change or getting cleaned up. Surveyor observed 2 flies on R13's bedroom window.*) R26 admitted to the facility on [DATE]. R26's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R26 has a Brief Interview for Mental Status (BIMS) score of 14 indicating R26 has intact cognition.On 8/28/25 at 9:47 AM, A Surveyor was interviewing R26. Surveyor observed a fly flying around R11 and landing on R26's hat. Surveyor observed R26 attempt to swat the fly away and stated, These darn flies.*) R75 was admitted to the facility on [DATE]. R75's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R75 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R75 has intact cognition.On 9/2/2025, at 9:40AM, Surveyor interviewed R75 who stated the flies have been really bad in the facility. Last couple weeks when it was really warm outside was the worst. R75 stated it is better but still get flies in the room daily. R75 stated R75 has reported the flies to staff.Surveyor observed 2 flies on R75's bedroom window. *) On 9/2/2025, at 10:12 AM, Surveyor observed flies on the ceiling right outside of the kitchen door in the basement level hallway. Surveyor observed that the kitchen door was open.*) R14 was admitted to the facility on [DATE]. R107's quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R07 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R107 has intact cognition.On 9/2/2025, at 11:18AM, Surveyor interviewed R107 who stated that the flies can get pretty bad especially when food is out, or garbage's are not emptied. R107 stated R107 has reported the fly issue multiple times to staff and management but they say nothing can be done about the flies. On 9/2/2025 at 11:23 AM, Surveyor interviewed licensed practical nurse (LPN, agency)-Y and certified nursing assistant (CNA)-Z who stated the flies can get really bad at times and can get very annoying. CNA-Z stated that staff report the flies to management but not sure if anything gets done about it because it seems like there are always flies around. LPN-Y stated that LPN-Y is agency staff so not in the facility often, but whenever LPN-Y does come to the facility there are always flies around. Surveyor observed flies flying around the 1-north nursing station.On 9/2/2025, at 12:23PM, Surveyor interviewed regional maintenance director (RMD)-CC and maintenance director-DD who stated that they were notified about flies couple weeks ago. Maintenance director-DD stated maintenance director-DD walked around the hallway with a fly swatter and killed flies. Maintenance director-DD stated that the 1-North hallway seems to get it the worst with flies because there is a back door at the end of the unit and when you exit out that door the dumpsters are located right outside that doorway. Maintenance director-DD stated that there are 2 bug zappers by the main exits, 1 located at the main entrance, and 1 located at that back door by the dumpsters. Maintenance director-DD stated that the pest control company was not contacted because the flies were no more than what there usually are in the facility. RMD-CC stated that there really is not