

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Waters Edge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3415 N Sheridan Rd Kenosha, WI 53140	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure a resident-to-resident altercation was thoroughly investigated for 1 (R2) of 1 resident-to-resident altercation reviewed. On 5/21/2026, R2 was involved in a resident-to-resident altercation. The Facility did not interview all staff that were present on the unit at the time of the incident. Findings include: The facility policy with a last reviewed date of 11/8/2023, titled Abuse, Neglect and Exploitation documents, in part: It is the policy of the facility that each individual will be free from Abuse . It is the policy of this facility that reports of abuse are promptly and thoroughly investigated . The investigation is the process used to try to determine what happened . Investigation of abuse includes identifying and interviewing others who might have knowledge of the allegations . R2 was admitted to the facility on [DATE] with diagnosis that includes Dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life) and adult maltreatment (encompasses the physical, emotional, or sexual abuse, neglect, financial exploitation, or self-neglect of a vulnerable adult (18 or older)). R2's admission Minimum Data Set (MDS) assessment dated [DATE] documents that R2 has a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment, hallucinates, has delusions, wanders and is independent with ambulation. Surveyor reviewed the Facility provided file for R2's resident-to-resident altercation investigation and noted the following: Per the Facility's Misconduct Report, R2 was involved in a resident-to-resident altercation on 5/21/2026, at 11:45 AM. R2 was observed bringing personal items into the dining room to pack to go see R2's friend who recently moved to another unit. R1 walked past R2's items that were brought into the dining room and R2 responded by pushing R1 with an open hand because R1 was too close to R2's belongings. R1 and R2 were immediately separated, police were notified, Physician and R2's power of attorney were notified. Skin assessments and pain evaluations were completed for R1 and R2 with no injuries noted. Surveyor reviewed the Facility provided file for R2's resident-to-resident altercation investigation and noted the following: A statement by Certified Nursing Assistant (CNA)-E, indicating CNA-E was passing lunch trays on the unit when she heard someone yelling from the dining room. CNA-E ran to the dining room and saw R1 getting up from the floor and R2 was standing over R1. CNA-E asked R1 what happened and R1 indicated R2 pushed them down. CNA-E then went to get management. There were no other staff statements provided by the Facility.		

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 1 (R2) of 4 sampled residents. On 5/21/2026, R2 was involved in a resident-to-resident altercation. The facility did not provide adequate supervision to prevent the resident-to-resident altercation. Findings include: R2 was admitted to the facility on [DATE] with diagnosis that includes Dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life) and adult maltreatment (encompasses the physical, emotional, or sexual abuse, neglect, financial exploitation, or self-neglect of a vulnerable adult (18 or older)). R2's admission Minimum Data Set (MDS) assessment dated [DATE] documents that R2 has a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment, hallucinates, has delusions, wanders and is independent with ambulation. R2's Care Plan indicates R2 is/has potential to be physically aggressive, by touching other residents/staff related to anger, dementia and poor impulse control, initiated on 11/20/2025 with the following interventions:-administer medications as ordered. Monitor/document side effects and effectiveness.-Assess and anticipate needs-Assess coping skills and support system-Assess understanding of the situation-Monitor verbally aggressive behaviors. Document observed behavior and attempted interventions-Psychiatric/Psychogeriatric consult as indicated-Staff approach calmly, use soft tone of voice, and clearly explain care.-Staff will prioritize active engagement and routine presence in common areas.- When agitated, intervene before escalation, guide away from source of stress, engage calmly in conversation; if response is aggressive, staff to walk away and approach later.-triggers for physical aggression when peers pace by R2's room or enter R2's room. Behaviors are de-escalated by redirection.-provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of agitation, assist to set goals for more pleasant behavior and encourage seeking out staff when agitated.-monitor stop signs across door. R2's progress note dated 5/21/2026 at 9:21 AM, by Social Services-D, documents in part: R2 exhibiting abusive language. R2 appears to be experiencing an increase in this expression, this expression is care planned and R2 is receiving psych services.R2's progress note dated 5/21/2026 at 9:43 AM, by Social Services-D, documents in part: R2 exhibiting wandering. This expression is care planned and R2 is receiving psych services.Per the Facility's Misconduct Report, R2 was involved in a resident-to-resident altercation on 5/21/2026 at 11:45 AM. R2 was observed bringing personal items into the dining room to pack to go see R2's friend who recently moved to another unit. R1 walked past R2's items that were brought into the dining room and R2 responded by pushing R1 with an open hand because R1 was too close to R2's belongings. R1 and R2 were immediately separated, police were notified, Physician and R2's power of attorney were notified and increased supervision for R2 was initiated. Skin assessments and pain evaluations were completed for R1 and R2 with no injuries noted.On 6/10/2026, at 10:00 AM, Surveyor observed R2 wandering the hallway on the unit until eventually sat in the common area briefly for coffee. On 6/10/2026, at 11:22 AM, Surveyor interviewed Social Services-D who indicated she did not observe the incident but went to the unit after it occurred. Social Services-D informed Surveyor that R2 is very protective of their belongings. Social Services-D spoke with R2 following the incident and R2 indicated being very upset that R1 was by R2's belongings. Social Services-D encouraged R2 to bring their belongings back to their room with no further incident. In collaboration with the interdisciplinary team (IDT), R2's care plan interventions were reviewed and revised. Surveyor asked Social Services-D about Social Services-D's progress note indicating an increase in behavior R2 was exhibiting just prior to the incident occurring. Social Services-D indicated that when a behavior is triggered in the electronic health record, usually by a Certified Nursing Assistant in the tasks section, Social Services-D receives an alert and follows up on the triggered behavior. Social Services-D indicated that the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior may have been from the previous day and was unable to clarify when R2 was experiencing the behaviors Social Services-D was following up on. Social Services-D notified psych services after the incident occurred and indicated she would expect an increase in monitoring and supervision to occur for R2 when they have an increase in behaviors.On 6/10/2026, at 1:20 PM, Surveyor interviewed Unit Manager-C who indicated R2 is known to be territorial over their belongings and care plan interventions have been in place to keep other residents out of R2's room for this reason. Unit Manager-C indicated that she was called to the floor after the incident between R1 and R2. Unit Manager-C observed R2 in the dining room with 2 plastic bags filled with R2's belongings and R2 stating fucking cunt taking my things. R2 was placed on 15-minute checks following the incident and the care plan was updated to include encouraging R2 to keep belongings in their room. Unit Manager-C informed Surveyor that when R2 exhibits an increase in behaviors, Unit Manager-C expects to be notified and increase supervision to be implemented.On 6/10/2026, at 3:02 PM, Surveyor informed the Facility of the concerns regarding R2.On 6/11/2026, at 10:35 AM, Surveyor interviewed DON-B who indicated that she would expect R2 to have an increase in supervision when experiencing and increase in behaviors to prevent altercations between R2 and other residents from occurring. No further information was provided.		