

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Water's Edge		STREET ADDRESS, CITY, STATE, ZIP CODE 11040 North State Rd 77 Hayward, WI 54843	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect 21 residents (R4, R10, R11, R12, R13, R14, R15, R16, R18, R19, R26, R27, R29, R6, R31, R32, R35, R36, R39, R40, and R41) of 39 residents on the Sunrise Bay Unit of the facility. Staff did not wear hair restraints properly while preparing food in the kitchenette. Staff did not perform hand hygiene with glove use. Staff did not consistently date or label food items when opened. Staff observed touching ready to eat food with contaminated gloves. Findings: Example 1 The 2022 FDA Food Code documents at 2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single use articles. Facility policy titled, Food Service Infection Control/Personal Hygiene (no revision date noted) Date of origin: 1987, stated in part: 6. Hair must be worn back from the face and off the collar. Hair should be kept clean, groomed, hair sprayed and /or [NAME] pinned. All hair must be contained/covered by hair net or cap and worn at all times in designated areas. On 06/29/2026 at 10:13 AM, Surveyor observed in Sunrise Bay kitchenette Certified Nursing Assistant (CNA) M put hair net on and did not pull up and cover the ponytail portion of her hair which hung down to the midback area. On 06/29/2026 at 10:18 AM, Surveyor asked CNA M if the ponytail portion of her hair sticking out of the back of the hair net was acceptable while working in the kitchen and serving food to the residents. CNA M shook her head in a No direction. Example 2 Facility policy titled, Hand Hygiene, revised 2/19/26, stated in part: .INDICATIONS FOR HANDWASHING AND HAND ANTISPESIS per WHO .3. Clean hands before donning gloves and after removal of gloves .7. Clean hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of patient .8. Before eating or preparing food and after using a restroom, wash hands with soap and water. On 06/29/2026 at 10:13 AM, Surveyor continued observation of CNA M in the kitchenette. CNA M washed hands in the sink, put on single use gloves, took a plate out of the refrigerator and placed it in the microwave. CNA M left the kitchenette to ask a kitchen staff person for a food thermometer. CNA M found the thermometer and took the temperatures of the food items on the plate with the gloved hands. CNA M removed the gloves and did not perform any hand hygiene. CNA M put on new gloves, took three juice glasses, and filled one with ice and water from the tap. CNA M took milk and juice out of the refrigerator, poured into the glasses and served residents in the dining room. On 06/30/2026 at 11:16 AM, Surveyor informed Director of Nursing (DON) B of the glove use without hand hygiene. DON B informed Surveyor hand hygiene is expected before putting on gloves and after removing gloves. Example 3 The 2022 FDS Food Code (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents at 3-501.18Ready-to-Eat, Time/Temperature Control for Safety Food: Disposition .A date marking system may be used which places information on the food, such as on an overwrap or on the food container, which identifies the first day of preparation, or alternatively, may identify the last day that the food may be sold or consumed on the premises. A date marking system may use calendar dates, days of the week, color coded marks, or other effective means, provided the system is disclosed to the Regulatory Authority upon request, during inspections.Facility policy titled, Nutrition Services, Label, Dating, Stocking of Food, Beverage and Supplies. For Care Center and Hospital stated in part: Policy Food, beverage, and supplies will be stocked in such a way as to maintain a standard par level of stock in each kitchen on units. As well as proper label and dating.Procedure1.Nursing will send requests to Nutrition Services when supplies are needed. Three times per week, the Nutrition Services staff or volunteers will check the amount of food and supplies needed in each hospital kitchenette. Nourishments include, but are not limited to, bread, margarine, peanut butter, jelly, ice cream, juices, milk, and instant breakfast drinks. Kitchenettes will be stocked as needed. All outdated items will be disposed of.2. Daily, the CNAs will check for items needed, checking for and disposing of outdated items.On 06/29/2026 at 10:13 AM, Surveyor observed CNA M pouring milk and juice into three different glasses. Surveyor noticed the top of the juice pitcher had a small 1/2 inch diameter sticker with a date on it. Surveyor asked CNA M if there was a date anywhere on the open and used gallon of milk. (The gallon of milk was about 2/3 full at this time). CNA M confirmed there was no date on the milk container. CNA M then served the milk to R6 sitting in the dining room.On 06/29/2026 at 8:37 AM, Surveyor asked Dietary Aide (DA) P if they could look at the milk jug in the refrigerator. DA P said, Sure, and pulled out the milk jug. No opened date noted on the used gallon of milk. Surveyor asked DA P, Do you typically mark the milk jug when you open it? DA P replied, No, we usually use it up that same day. Surveyor asked, What if something gets pushed in front of it like a gallon pail of something? DA P replied, No, we use it up right away. Surveyor asked, So, it is not a common practice to mark a gallon of milk with the date opened? DA P replied, No. Surveyor noted there were other staff in the kitchenette listening and did not say anything.On 06/30/2026 at 9:09 AM, Surveyor asked Dietary Manager (DM) Q, Is it a common practice to label a gallon of milk with the date that it is opened? DM Q replied, No, because we go through it right away. Well except one time there was a gallon of whole milk that was not being used right away.Example 4The 2022 FDA Food Code documents 3-304.15 Gloves Use Limitation: (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.On 06/29/2026 at 12:55 PM, Surveyor observed DA N serving hot food in the Sunrise Bay unit wearing blue single use gloves. DA N was touching multiple potentially contaminated surfaces with gloved hands. Surveyor observed DA N touching lids that covered the hot food items, ladles, the steam table edging directly in front of her, plates, and multiple bun bags. Surveyor then noted that DA N picked up a bun with the contaminated gloves, put it on a plate, then put a cheeseburger on the bun using tongs, and then placed the top of the bun on the cheeseburger. Surveyor observed DA N pick up half of a cheeseburger (that was cut previously) and place it on a plate with the same contaminated gloves and then served it to the resident in the dining room.On 06/29/2026 at 9:11 AM, Surveyor informed DM Q of this observation. DM Q replied, No, this is not our practice.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not allow the right to exercise autonomy when choosing a mealtime preference for 1 resident (R10) of 13 residents reviewed for self-determination in a sample of 13 residents. The facility did not allow R10 to have a bowl of soup when requested because it was not during a facility scheduled mealtime. This resulted in R10 being denied the right to make choices about aspects of life that are significant to R10 that could lead to psychosocial harm. Findings: The facility policy titled Water's Edge Care Center Rights of Residents, last revised 04/03/2026, states, The resident has a right to choose activities, schedules. the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. R10 was admitted to the facility on [DATE]. R10 has a Brief Interview for Mental Status (BIMS) score of 11/15, which indicates moderate cognitive impairment. R10 makes own healthcare decisions. R10's care plan, dated 11/20/2025, states, I need some assistance because I have mild cognitive impairment. I need my aides to: Is willing to have the lunch meal small portions. Please bring the lunch meal to her and then if she chooses not to eat it, offer soup and sandwich. On 06/29/2026 at 11:00 AM, Surveyor observed R10 asking certified nursing assistant (CNA) M for a bowl of tomato soup to be delivered to room. Surveyor observed CNA M inform R10 that lunch would be served in 1.5 hours and R10 could have tomato soup then. R10 told CNA M because R10 did not eat much for breakfast, and was now hungry, R10 would like to have a bowl of soup earlier than the scheduled mealtime. CNA M informed R10 they had another resident to attend to first, then CNA M would bring R10 a bowl of tomato soup in about 30 minutes time. R10 was agreeable to this plan. On 06/29/2026 at 12:08 PM, Surveyor observed a bowl of tomato soup had not been delivered to R10. On 06/29/2026 at 1:04 PM, Surveyor observed R10 ambulating into hallway outside of room. CNA O asked R10 where she was going and R10 told CNA O, I was wondering where my food is, I have been waiting and waiting. On 06/29/2026 at 1:05 PM, Surveyor observed CNA O deliver a tray of tomato soup and ice cream to R10's room. Surveyor asked R10 how the lunch was that was served to her and R10 stated, I am glad it finally got here. R10 informed Surveyor they had requested it earlier and had to wait until lunch time to get it. R10 stated they did not eat much for breakfast as they did not feel well earlier that morning. On 06/30/2026 at 1:30 PM, Surveyor interviewed Director of Nurses (DON) B what the facility's expectations are of staff when a resident asks to be served food outside of a scheduled lunch mealtime. DON B stated, Inform them lunch is an hour away. DON B stated the facility has pre-made sandwiches and salads supplied in the kitchen for residents who want something to eat in between meals. Surveyor asked DON B what staff do when a resident requests a food item that is not a salad or sandwich, such as soup. DON B stated the soup can be offered at lunch time. Surveyor asked DON B if cans of condensed soup are available for staff to heat up between meals or after kitchen hours. DON B confirmed there are condensed cans of soup for residents upon request. Surveyor asked DON B if residents have the right to request food/snacks during all hours of the day and DON B stated, Yes.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not notify the provider of changes for 1 of 13 residents (R7) reviewed out of 13 sampled residents. R7's weight increased and the provider was not notified per provider's order. This is evidenced by: Facility policy titled, 'Change of Condition,' with no date, states: Immediate notification any symptom, sign, behavior or complaint this is: acute or sudden in onset and a marked change in relation to usual symptoms and signs or unrelieved by measures already prescribed. R7 was admitted to the facility on [DATE] with edema. Surveyor reviewed R7's medication administration record (MAR): On 03/06/26, R7's weight was 283.6 lb. On 03/07/26, R7's weight was 292 lb. Provider was notified and new order entered: Weight gain greater than 3 lb. give 10 mg furosemide and notify primary care provider. On 04/03/26, R7's weight increased by 3.2 lb. overnight. -No notification to provider documented. On 04/18/26, R7's weight increased by 3 lb. overnight. -No notification to provider documented. On 05/12/26, R7's weight increased by 7.6 lb. overnight. -No notification to provider documented. On 05/29/26, R7's weight increased by 3.2 lb. overnight. -No notification to provider documented. On 06/24/26, R7's weight increased by 3.2 lb. overnight. -No notification to provider documented. On 06/30/26 at 2:51 PM, Surveyor interviewed Registered Nurse (RN) L regarding provider notification. Surveyor asked RN L when nursing would be expected to notify the provider of changes. Surveyor asked RN L if nursing would be expected to document in resident's chart when contacting the provider. RN L stated yes. On 06/30/26 at 3:14 PM, Surveyor interviewed Director of Nursing (DON) B regarding notifying the provider of R7's weight increases. Surveyor informed DON B of findings of R7's weight increase and no documentation of notifying provider. Surveyor asked DON B what the expectation for nursing staff would be. DON B stated that nursing is expected to follow the provider's orders to notify of changes and to document the communication in the resident's chart. DON B stated this should have been done for R7's weight increases.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 1 (R21) of 13 sampled residents was provided privacy during personal cares. *Certified Nurse Assistant (CNA) C did not provide R21 privacy to use the toilet as requested from R21. Findings include: Surveyor reviewed facility policy titled, Rights of Residents, dated last revised 04/03/26, states: .(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would danger the health or safety of the resident or other residents. (h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, and personal care . R21 was readmitted to the facility on [DATE] with diagnoses including sick sinus syndrome, anemia, hyperlipidemia, seizure disorder, anxiety, and depression. R21's Minimum Data Set (MDS) assessment, dated 05/27/26, identified R21 scored 5/15, during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was dependent on toileting, upper/lower body dressing, and personal hygiene. Surveyor reviewed R21's Activities of Daily Living (ADL) care plan, Toilet Transfer: With two helpers providing more than half the effort using pivot transfer and gait belt. -Toilet hygiene with 1 helper providing usually more than half the effort. -R21 wears incontinent briefs and needs help adjusting clothes.-Please follow my bowel and bladder program to promote continence, decrease the risk for falls and decrease risk for skin injuries: 7-7:30 AM, 11:30-12 PM, 1:30 PM-2 PM, 4:30-5 PM, 6:30 PM-7 PM upon arising before and after meals and prior to going to bed for the night. On 06/30/26 at 7:52 AM, Surveyor observed CNA C enter R21's room to assist with R21's ADLs for the morning. Surveyor observed CNA C walk over to R21 and began setting up washcloths for washing R21. CNA C placed gait belt on R21. CNA D entered to assist CNA C with transferring R21 to the toilet. CNA C wheeled R21 into bathroom and CNA D assisted. Surveyor observed CNA C and CNA D transfer R21 to the toilet. R21 sat on toilet and stated, I think I have to go to the bathroom. CNA C reported to R21 once CNA C was done getting R21 dressed for the day, CNA C would step out to give privacy. Surveyor observed CNA C gather washcloths, clothes, and shoes to dress R21. Surveyor observed CNA D assist CNA C with dressing R21. CNA C stated to Surveyor, [R21] is very private and has a bashful bladder, so we will step out soon for [R21]. R21 responded, Yes, I have a bashful bladder. Surveyor observed CNA C continue to dress R21. CNA C asked R21 to stand as it was time to get off the toilet and transfer to wheelchair. R21 stated, I don't think I peed yet, at least I can't remember if I did. CNA D reported to R21, CNA D did not hear or observe R21 urinate, but R21 could try to use bathroom after breakfast. Surveyor observed R21 sit in silence and then stand when CNA D and CNA C prompted R21 to stand. Surveyor observed R21's transfer to wheelchair, and R21 was wheeled out of room down to the dining room. On 06/30/26 at 8:58 AM, Surveyor observed CNA C approach R21 in dining room and ask if R21 was done eating breakfast so that CNA C could take R21 back to R21's room. R21 reported to CNA C that R21 was ready to go back. CNA C wheeled R21 to R21's room and parked R21 in room. Surveyor asked CNA C if they were going to be taking R21 to the bathroom since R21 did not use the toilet prior to breakfast. CNA C reported to Surveyor they will go grab another aide to help sit R21 on the toilet since R21 did not go prior to breakfast. CNA C exited R21's room to grab CNA E. On 06/30/26 at 9:03 AM, Surveyor observed CNA C and CNA E enter R21's room and took R21 into the bathroom. As CNA C and CNA E were lifting R21 to the toilet, R21 stated, Oh no, I am peeing (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right now. CNA C and CNA E lowered R21 to the toilet, and R21 continued to urinate in the toilet. Surveyor observed CNA C grab R21's insert pad from inside R21's underwear which appeared sopping wet, and CNA C threw it in the trash and replaced with a dry pad. R21 stated, I am sorry, I have a bashful bladder. CNA C instructed R21 that staff would step out so that R21 had more privacy while R21 continued to pee. On 06/30/26 at 9:08 AM, Surveyor asked CNA C if R21's pad inside was wet. CNA C reported to Surveyor that R21's pad was in fact wet. Surveyor asked CNA C if R21 had urinated prior to breakfast. CNA C reported to Surveyor that R21 did not prior to breakfast and CNA C probably should have stepped out while CNA C was getting R21 ready for the day while in the bathroom. CNA C reported to Surveyor, R21 probably would have urinated if CNA C had left the bathroom and given them time. On 06/30/26 at 11:39 AM, Surveyor interviewed R21's Family Member (FM) G and asked if there are particular needs R21 requires while using the restroom. FM G reported to Surveyor, R21 is very private when it comes to the bathroom so R21 likes to have privacy while on the toilet. FM G reported they will step out of bathroom and leave door cracked to provide privacy but still keep R21 safe while in bathroom. On 06/30/26 at 1:29 PM, Surveyor interviewed Director of Nursing (DON) B and reported Surveyor's observation of CNA C providing cares to R21 for toileting. R21 requested privacy to use the bathroom, CNA C did not provide privacy to R21 and then R21 was not able to urinate as R21 requested. Surveyor asked DON B's expectation for CNA C to provide privacy for R21 as requested. DON B reported to Surveyor the expectation would be CNA C should have stepped out of the bathroom so that R21 could use the bathroom in private.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not use the least restrictive device and document on-going re-evaluation of the need for the restraint for 1 (R34) of 13 sampled residents reviewed for restraints. R34 was placed in a recliner chair with the footrest elevated and recliner unplugged from the wall, which R34 could not independently release the footrest to have unrestricted movement. Findings include: Surveyor reviewed facility policy titled, Rights of Residents, dated last revised 04/03/26, states: .(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with S483.12(a) . Surveyor reviewed facility policy titled, Physical Restraints and Resident Rights, dated last revised 12/04/25, which states: .A physical restraint is a prescription device that is defined as: 1) any article, device, or garment that is used primarily to modify a resident's behavior by interfering with the free movement of the resident, and which the resident is unable to remove easily. R34 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, spinal stenosis, atrial fibrillation, and chronic kidney disease. R34's Minimum Data Set (MDS) assessment, dated 05/13/26, identified R34 scored 3/15 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R34 had no impairment to upper or lower extremities. R1 was dependent on toileting, transfer with non-mechanical lift and assist of one, upper/lower body dressing, and personal hygiene. Surveyor reviewed R34's Activities of Daily Living (ADL) care plan:-On 05/05/26, Power recliner not to be plugged in. Cannot be used to elevate legs (example plug in elevate legs then unplug) as this would be a restraint. OT will provide a footstool for her to elevate feet. Surveyor reviewed Occupational Therapy (OT) notes, in part, -On 05/07/26 at 6:54 AM, Use of chair control poor. [R34] raised versus lowering seat surface when asked to extend leg rests. OT unplugged power from wall for patient safety.-On 05/15/26 at 11:06 AM, [R34] seated in recliner chair, unplugged from wall. On 06/29/26 at 10:32 AM, Surveyor entered R34's room. Surveyor observed R34 sleeping in recliner with footrest in the up position. Upon entrance to R34's room, Surveyor observed recliner electrical cord unplugged from the wall lying on the floor next to recliner. On R34's wall to the right of the recliner a wall sign stated, Keep recliner unplugged. Surveyor observed R34's recliner unplugged from the wall. On 06/30/26 at 11:37 AM, Surveyor observed R34 sitting in recliner with R34's feet in the up position on the footrest. R34 was yelling out for assistance. Surveyor entered R34's room and asked if R34 is ok. Upon entrance into R34's room, Surveyor observed recliner electrical cord unplugged from the wall lying on the floor next to recliner. R34 reported to Surveyor they want to get out of their chair as it's uncomfortable, and R34 wanted to go eat lunch. Surveyor observed R34 slightly agitated as R34 wanted to get out of recliner. Surveyor let R34 know Surveyor would go get assistance for R34. Surveyor exited R34's room. On 06/30/26 at 11:47 AM, Surveyor approached Certified Nurse Assistant (CNA) D and reported R34 wanted to get out of recliner. Surveyor observed CNA D enter R34's room and Surveyor followed. CNA D walked straight over to R34's recliner cord lying on the floor and plugged R34's recliner cord into the electrical outlet on the wall. On 06/30/26 at 11:55 AM, Surveyor interviewed CNA D and asked why R34's recliner was unplugged. CNA D reported to Surveyor R34's recliner stays unplugged while R34 is in recliner for safety concerns. Surveyor reported to CNA D Surveyor's observation of R34 having a sensor pad under R34 in recliner and would CNA D think the sensor pad was enough safety to let staff know R34 was trying to get out of the (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recliner. CNA D reported R34's recliner is unplugged and R34's feet are up because R34 likes to shimmy downwards to end of footrest and get out of recliner. Surveyor asked CNA D if it is normal to have recliner unplugged and R34's feet elevated with footrest up. CNA D reported to Surveyor that CNA D did not want to tell Surveyor wrong information so CNA D would ask someone. On 06/30/26 at 12:14 PM, Surveyor interviewed CNA D and asked if CNA D asked for clarification on R34's recliner being unplugged with R34's footrest up. CNA D reported to Surveyor CNA D spoke with Registered Nurse (RN) F, and RN F reported the recliner being unplugged is for R34's safety. On 06/30/26 at 12:23 PM, Surveyor interviewed Physical Therapy (PT) H and Occupational Therapy (OT) I and asked how assessments are conducted for residents to safely use recliner. OT I reported to Surveyor once a resident receives a recliner, OT I and PT H will assess residents for recliner safety and then report the assessment findings and recommendations to the Interdisciplinary Team (IDT). PT H reported to Surveyor assessment of safety for recliner use is a group effort and is communicated with the entire team. Once determination of safety, nursing staff is made aware, and nursing staff implements interventions. Surveyor asked PT H's expectation how residents are to use recliners once deemed not safe to utilize. PT H reported nursing staff is made aware of the safety concern, nursing types a paper that states, Unplug recliner from wall, and then places in resident's room. PT H reported to Surveyor residents can be placed in recliner, but staff need to ensure feet are in the down position when sitting residents in an unplugged recliner. Surveyor asked OT I's expectation for R34 in recliner when in room. OT I reported R34 should have recliner unplugged from the wall but be placed in a sitting position in recliner, always. On 06/30/26 at 12:48 PM, Surveyor interviewed Registered Nurse (RN) F and asked RN F's expectation for recliner use for R34. RN F reported R34 has been deemed to be unsafe with recliner remote use, so staff are to unplug recliner from wall with resident in recliner in sitting position. Surveyor reported to RN F Surveyor observed CNA D transferring R34 out of recliner but upon entering the room, R34 has had her legs up on the footrest in the recliner with the recliner unplugged. RN F reported to Surveyor aides should not be placing any residents in recliners with feet up with the recliner unplugged. On 06/30/26 at 1:29 PM, Surveyor interviewed Director of Nursing (DON) B and reported to DON B Surveyor observed R34 on 06/29/26 most of day sitting in recliner with feet up on footrest with recliner unplugged. Surveyor also informed DON B of Surveyor's observation of R34 sitting in recliner on 06/30/26 yelling for assistance while sitting in recliner that is unplugged with feet up on footrest. Surveyor asked DON B's expectation for how staff are to place R34 in R34's unplugged recliner. DON B reported to Surveyor CNA D should have had R34's feet down in a sitting position. DON B reported for any residents who are unsafe to use recliner remote they should be left in recliner in a sitting position and never with feet up if unplugged from the wall.		

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NAME OF PROVIDER OR SUPPLIER Water's Edge		STREET ADDRESS, CITY, STATE, ZIP CODE 11040 North State Rd 77 Hayward, WI 54843	
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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 observation, interview and record review, the facility did not ensure residents received adequate assistance devices and supervision to prevent accidents for 2 residents (R6, R21) of 7 residents reviewed for accidents/hazards in a sample of 13 residents. -R6 was assisted from sitting to standing position by Certified Nursing Assistant (CNA) staff without the use of a gait belt device. -R6 was transferred from toilet to wheelchair with a nonmechanical lift assist device by one CNA staff person when R6's care plan directs 2 persons assist when using lift device.-R6 was left unattended on the toilet by staff when R6's care plan indicated to not leave R6 unattended during toileting. -R21 was assisted from a sitting to standing position by CNA staff without the proper use of a gait belt. The facility staff's lack of proper use of assisted devices during transferring of residents and leaving residents unattended during toileting could result in physical harm to R6 and R21. Findings include: The facility policy, titled Safe Resident and Tenant handling, last revised 12/02/2025, states, Avoid hazardous resident/tenant handling and movement tasks whenever possible.use resident/tenant handling equipment and other approved resident/tenant handling aids for high-risk resident/tenant handling and movement tasks. Example 1 R6 was admitted to the facility on [DATE] with diagnoses including history of falling, bilateral cataracts, metabolic encephalopathy and diabetes. R6 has a Brief Interview for Mental Status (BIMS) score of 15/15, which indicates R6 is cognitively intact. R6's Minimum Data Set (MDS) assessment, dated 05/22/2026, indicated R6 is dependent on staff with toileting to chair and bed to chair transfers. R6's care plan, last revised on 06/03/2026, with a target date of 09/03/2026, states: I can't complete cares on my own because I have weakness, fatigue.impaired mobility.I transfer with 2 helpers providing less than half the effort to more than half the effort with EZ Way and use of gait belt for sit to stand, chair/bed to chair transfer.DO NOT LEAVE UNATTENDED IN THE BATHROOM &ndash; HIGH FALL RISK. On 06/30/2026 at 7:55 AM, Surveyor observed CNA M leave R6's room after assisting him to the bathroom. R6 was left unattended on the toilet with EZ Way device (a non-mechanical transfer assist) in front of him. CNA M returned to R6's room to finish assisting with toileting needs at 8:03 AM. On 06/30/2026 at 8:03 AM, Surveyor observed certified nursing assistant (CNA) M assisting R6 during toileting. CNA M attempted to place gait belt around R6's waist when R6 commented, You have never (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done that before, no one uses that. CNA M informed R6 he had the right to refuse the use of the gait belt stating, We ask you, but you refuse to wear it. R6 responded to CNA M with, I have never had anyone ask me before. CNA M proceeded to assist R6 to a standing position without the use of the gait belt. CNA M informed Surveyor, if R6 refuses gait belt, they do not use it. Using the EZ Way device, CNA M transferred R6 from the bathroom to the wheelchair, which was placed outside of the bathroom and across the room next to R6's bed. CNA M did not call for another staff person to assist during the transfer. CNA M lowered R6 into his wheelchair without the use of a gait belt. On 06/30/2026 at 8:15 AM, Surveyor asked R6 if staff normally use the gait belt during transfers and R6 stated, I don't know that I should say anything. On 06/30/2026 at 10:30 AM, Surveyor asked CNA M how staff know transferring status on residents. CNA M stated they follow a resident's care plan. CNA M stated care plans are available to view on the resident's electronic medical record. On 06/30/2026 at 1:30 PM, Surveyor interviewed director of nurses (DON) B what the facility's expectations are of CNA staff to safely transfer residents using the EZ Way. DON B stated a gait belt is always used during any type of transfer. DON B stated one person can transfer a resident with the EZ Way, however agreed that if a resident's care plan indicates using 2 persons during transfers of any kind, then CNA staff need to follow care plan directions for a resident's safety. DON B stated a resident's wheelchair should be placed as close as possible to lessen the distance a resident has to be transferred using the EZ way. DON B confirmed pushing a resident in an EZ Way from the bathroom across the room with only one person assisting, was not optimal for resident safety. Example 2 R21 was readmitted to the facility on [DATE] with diagnoses including fracture of the left humerus, sick sinus syndrome, anemia, hyperlipidemia, seizure disorder, anxiety, and depression. R21's Minimum Data Set (MDS) assessment, dated 05/27/26, identified R21 scored 5/15 during a Brief Interview for Mental Status (BIMS), indicating impaired cognition. R1 had no impairment to upper or lower extremities. R1 was dependent on toileting, upper/lower body dressing, and personal hygiene. R21 is a fall risk. Surveyor reviewed R21's Activities of Daily Living (ADL) care plan, -Toilet Transfer: With two helpers providing more than half the effort using pivot transfer and gait belt. On 06/30/26 at 7:52 AM, Surveyor observed Certified Nurse Assistant (CNA) C enter R21's room to get up for the morning. CNA C walked over to R21 and placed gait belt on R21's upper chest under arm pits. CNA D entered to assist CNA C with transferring to toilet. Surveyor observed CNA D grab underneath R21's gait belt from behind and instructed R21 to stand on the count of 3. CNA C grabbed under R21's armpits to lift from the front. CNA C lifted R21 by armpits while CNA D lifted R21 from behind with gait belt. CNA C transferred R21 to wheelchair. CNA C wheeled R21 into bathroom and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA D assisted. Surveyor observed CNA C instruct R21 to stand as CNA C and CNA D lifted R21 to the toilet. Surveyor observed CNA C grabbing under R21's left arm to assist picking up R21 to transfer to the toilet. R21 sat on the toilet. CNA D prompted R21 to stand. CNA D asked R21 to stand up and assisted by grabbing the gait belt to lift R21 off toilet. Surveyor observed CNA C grab under R21's right armpit again until R21 could grab the toilet assist bar. CNA C then pulled R21's pants up and assisted R21 to the wheelchair by grabbing under R21's armpit. Surveyor observed R21 transferred to wheelchair and wheeled out of room down to the dining room. On 06/30/26 at 8:15 AM, Surveyor interviewed CNA C and asked if it was normal process to grab R21 under armpits to transfer from recliner to wheelchair, and from wheelchair to the toilet. CNA C reported to Surveyor CNA C sometimes grabs one side of the gait belt and then the other side under R21's armpit depending on how R21 stands for CNA C. On 06/30/26 at 1:29 PM, Surveyor interviewed Director of Nursing (DON) B and reported Surveyor's observation of CNA C providing cares to R21 for toileting and during transfer CNA C applied gait belt to upper chest area on R21 above breasts but lifted R21 under R21's arm pits and under arms. Surveyor asked DON B's expectations for CNA C transferring with gait belt. DON B reported CNA C is supposed to apply the gait belt at the lower half of waist then CNA C is to grab the gait belt on each side on R21 and not under R21's armpits.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure residents were free of significant medication errors for 1 of 5 residents (R7) reviewed from a sample of 13 residents. R7's sliding scale insulin and as needed (PRN) furosemide were not administered per physician orders having the potential to cause harm. This is evidenced by: Facility policy titled, 'Medication Administration,' with a reviewed date of 12/03/25, states: All medications will be administered according to physician order and documentation of administration recorded appropriately in the resident's medical record. R7 was admitted to the facility on [DATE] with type 2 diabetes mellitus and edema. R7's physician orders: -insulin lispro 100 unit/ml sub Q per sliding scale four times a day: <70 = initiate hypoglycemic protocol 150-199 = 1 units 200-249 = 2 units 250-299 = 3 units 300-349 = 4 units >349 = 5 units call MD-furosemide 20 mg tab give 0.5 tab (10 mg) PO daily PRN for wt gain of 3 pounds overnight. Surveyor reviewed R7's medication administration record (MAR): 03/06/26, R7's weight was 283.6 lb. 03/07/26, R7's weight was 292 lb., an increase of 8.4 lb. PRN furosemide was not administered per physician orders. 04/02/26, R7's weight was 281.6 lb. 04/03/26, R7's weight was 284.8 lb., an increase of 3.2 lb. PRN furosemide was not administered per physician orders. 04/17/26, R7's weight was 282.8 lb. 04/18/26, R7's weight was 285.8 lb., an increase of 3 lb. PRN furosemide was not administered per physician orders. 04/30/26, R7's AM blood glucose was 404 and 4 units of insulin lispro were administered. Physician orders were not followed; 5 units of insulin should have been administered. 05/19/26, R7's weight was 290.4 lb. 05/20/26, R7's weight was 298 lb., an increase of 7.6 lb. PRN furosemide was not administered per physician orders. 05/28/26, R7's weight was 290.4 lb. 05/29/26, R7's weight was 293.6 lb., an increase of 3.2 lb. PRN furosemide was not administered per physician orders. 06/23/26, R7's weight was 300.2 lb. 06/24/26, R7's weight was 303.4 lb., an increase of 3.2 lb. PRN furosemide was not administered per physician orders. On 06/30/26 at 2:51 PM, Surveyor interviewed Registered Nurse (RN) L regarding R7's PRN furosemide. Surveyor asked RN L to review R7's MAR to verify if PRN furosemide had been administered. RN L reviewed R7's MAR and stated no PRN furosemide had been administered on the dates when R7's weight had increased 3 lb. Surveyor asked RN L if R7 should have received the PRN furosemide. RN L stated yes. On 06/30/26 at 3:27 PM, Surveyor interviewed Director of Nursing (DON) B regarding R7's medications. Surveyor explained to DON B the findings on R7's MAR of administering only 4 units of insulin when the provider's orders noted that 5 units should have been administered on 04/30/26. DON B nodded head in recognition. Surveyor also told DON B finding of numerous dates when R7's weight increased by 3 lb. and R7's PRN furosemide had not been administered. Surveyor asked DON B what the expectation was for nursing staff when R7's weight increased by 3 lbs. DON B stated that nursing would be expected to follow the provider's orders and administer the PRN furosemide.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 6 residents (R20) reviewed from a sample of 13 residents. R20's pharmacy labels for toremide, spironolactone, and gabapentin did not match the physician order. This is evidenced by: Facility policy titled, 'Medication Administration,' with a reviewed date of 12/03/25, states: All medications will be administered according to physician order and documentation of administration recorded appropriately in the resident's medical record. General: 6. Medication directions on the pharmacy label should correlate with the medication directions on the MAR. On 07/01/26 at 7:35 AM, Surveyor observed Medication Aide (MA) J prepare and administer medications during medication administration task. Surveyor observed MA J remove R20's medication bin from the cabinet and prepare R20's medications. MA J opened one of the bottles, removed 1 tab and handed the bottle to the Surveyor. Surveyor observed the pharmacy label stated toremide 20 mg with printed instructions to give 1 tab in AM and 1 tab in PM. The number 1 was crossed off with a black marker and handwritten a number 2. Surveyor asked MA J what this handwritten number on the label meant. MA J stated that the order must have changed and someone changed it on the label. Surveyor looked at R20's physician order on the medication administration record (MAR) and noted: toremide 40 mg 1 tab twice daily. Surveyor asked MA J to look at the prescription bottle and order again. MA J looked and stated that it was right because the order in the MAR said 1 tab. Surveyor again asked MA J to re-check. MA J looked again and stated, Oh, it should be 2 tabs because the order in the MAR says 40 mg. I got confused because the MAR said 1 tab. MA J continued preparing R20's medications and Surveyor observed 2 more prescription bottles have the handwritten changes in marker on the prescription bottle pharmacy label: -2 tabs spironolactone 25 mg daily had the 2 crossed off and a 1 written on top. -2 tabs gabapentin 300 mg three times a day had the 2 crossed off and a 3 written on top. Surveyor reviewed R20's physician orders: 03/25/26 toremide 40 mg PO take 1 tab daily. -Pharmacy label on bottle stated toremide 20 mg take 1 tab in AM and 1 tab in PM. Both number 1's crossed off and changed to 2 in marker. 03/25/26 spironolactone 50 mg take 1 tab PO daily. -Order updated 06/08/26: 25 mg take 1 tab PO daily. 03/25/26 gabapentin 300 mg take 2 caps PO three times daily. -Order updated 06/16/26: 300 mg take 3 caps PO three times daily. On 07/01/26 at 7:54 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K regarding process for medication changes and pharmacy labels. Surveyor asked LPN K what nursing staff does when a provider changes a medication order and the pharmacy label does not match. LPN K stated that the nurse verifies the order, has a new label for the bottle made, and updates the order in the MAR to match. LPN K stated that the order should always match the prescription bottle. On 07/01/26 at 8:06 AM, Surveyor interviewed Director of Nursing (DON) B regarding observation during medication pass. Surveyor asked DON B what the expectation is for nursing staff when a medication order is changed and no longer matches the pharmacy label on the bottle. DON B stated that the expectation is for nursing to ensure that the order in the MAR matches the label and this should have been changed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections when staff did not perform hand hygiene after removing soiled gloves during care observations. This affected 1 of 6 residents (R) observed for cares. (R21) Certified Nursing Assistant (CNA) C did not perform hand hygiene when changing gloves while performing peri care for R21. Findings include: On 06/30/26 at 7:52 AM, Surveyor observed CNA C enter R21's room to get R21 up for the morning. CNA C walked over to R21 and transferred R21 to wheelchair. CNA C wheeled R21 into bathroom and CNA D assisted. Surveyor observed CNA C apply gloves and gather washcloths, clothes, and shoes to dress R21. Surveyor did not observe CNA C perform hand hygiene prior to donning gloves. Surveyor observed CNA D assist CNA C with dressing R21's lower body with R21's shoes, underwear, and pants. Surveyor observed CNA C remove gloves and then apply another pair of gloves. CNA C asked R21 to stand as it was time to get up off the toilet and transfer to wheelchair. Surveyor observed CNA C stand R21. Surveyor observed CNA C don gloves. CNA C washed R21's peri care area with washcloth and soap, then dried with towel. Surveyor observed CNA C pause for a second, looked around the bathroom at the glove box, and then proceeded to pull R21's underwear and pants up with contaminated gloves. Surveyor did not observe CNA C doff contaminated gloves. CNA C pulled R21's pants up and assisted R21 to the wheelchair by touching under R21's armpit with contaminated gloves. Surveyor observed CNA C touch R21's wheelchair brakes and handles with contaminated gloves. Surveyor observed CNA C continues to grab R21's trash and clothing items out of bathroom with contaminated gloves and then doffed contaminated gloves and walked out of R21's room. Surveyor observed that CNA C did not sanitize hands prior to donning gloves, or removing gloves. On 06/30/26 at 8:15 AM, Surveyor interviewed CNA C and asked about performing hand hygiene in between glove changes and changing gloves from cleaning peri care area to pulling R21's clean pants up. CNA C stated, Yea, I forgot. On 06/30/26 at 1:29 PM, Surveyor interviewed Director of Nursing (DON) B and reported to DON B, CNA C provided cares to R21 for toileting and did not sanitize hands prior to donning gloves and in between glove changes. Surveyor asked for DON B's expectation for hand hygiene. DON B reported CNA C should have sanitized hands prior to applying gloves and in between.		