STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAY AT WATERS EDGE HEALTH AND REHABILITATION (THE)	**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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not promptly resolve grievances for 1 of 1 resident grievance reviewed (R6). Findings include: R6 is [AGE] years old and was admitted to the facility for rehabilitation on 2/5/20. On 2/27/20, the state agency received a complaint from R6's family, who will be referred to as Family - C. The complaint alleged that the facility had not responded to Family - C's grievance that alleged the following; R6 had no wheelchair and was therefore unable to get out of bed for 3 weeks. R6's therapy was delayed. R6 had gained water weight and had a cough that was not being monitored. R6 was not receiving ordered medication for his eyes. R6's room was dimly lit and R6 felt isolated, with no intervention from the facility. On 3/16/20 at 12:36 PM, Nursing Home Administrator (NHA) - A was informed of the preceding grievance and said that she recalled speaking to Family - C. NHA - A was asked to provide any information about the facility's handling of the grievance. On 3/17/20 at 8:49 am, NHA - A provided a copy of an email that was sent to NHA - A from Family - C. The email was dated 2/24/20 and alleged the same concerns that Family - C had sent to the state agency on 2/27/20. At that time, NHA - A said she had no information indicating that the facility had responded to Family - C's concerns. On 3/17/20 at 9:36 am, Director of Nursing (DON) - B provided the following documentation related to Family - C's grievance. On 2/24/20, the maintenance department had completed a request to check the lights in R6's room. The form simply noted that the lights had been checked and no lights were out. On 2/24/20, nursing staff had documented that R6 had a cough, the physician had been notified, and the physician had ordered labs. The information provided by DON - B did not address all of Family - C's concerns. When asked if this information had been shared with Family - C, DON - B said that it had not. Although the facility attempted to address some of the issues; not all of the issues were addressed and R6's family was not informed of what was being done to address their concerns.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.