STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075381	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Water's Edge Center for Health & Rehab	111 Church Street Middletown, CT 06457

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure staff reported an allegation of abuse timely. The findings include: Resident #1's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment, was dependent for ADLs, and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 9/10/2024 identified Resident #1 had deficit in self-care function related to impaired mobility, limited functional ability, cognitive deficit and incontinence. Interventions directed assist of two (2) for bed mobility, bed level rolling, turned, repositioned slowly assisted by two (2) staff members while reassuring the resident he/she is safe bathing, dressing, transfers, and mechanical lift for transfers. Nursing note written by RN #1 on 1/4/2025 at 9:31 AM identified Resident #1 sustained a left eye bruise and cut from Hoyer lift sling attachment. Resident #1 reportedly had been agitated and banged his/her head on the pillow and then the device. The area was cleansed, and one steri-strip was applied. The MD and responsible party notified were notified, and the plan of care was updated to direct the sling was not to be attached until the resident was ready for immediate transfer. The facility reportable event dated 1/9/2025 at 6:35 PM identified NA #1 alleged that NA #2 could have struck Resident #1 in the face during care. NA #1 alleged she heard Resident #1 yell out and say, she punched me in my eye, while NA #2 was providing care. The facility summary report dated 1/13/2025 identified that on 1/9/2025 NA #1 reported to the supervisor that on 1/4/2025 she heard Resident #1 yell out and say, she punched me in my eye, while NA #2 was providing care. Following this, NA #1 entered Resident #1's room and observed a discoloration and an open area to his/her left lower eye. NA #2 who was caring for Resident #1 stated that she wasn't sure how the resident sustained the discoloration, but noted that Resident #1 was very combative during care and she denied inflicting the injury. Both NAs were suspended pending the investigation. Interview, facility documentation review on 1/30/2025 at 11:19 AM with NA #1 identified on 1/4/2025 she heard Resident #1 say that NA #2 hit him/her, and she reported the incident on 1/9/2025 to RN #1. NA #1 stated she should have reported the allegation to her supervisor right away on 1/4/2025 instead of waiting another five (5) days to notify a supervisor. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075381	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Water's Edge Center for Health & Rehab	111 Church Street Middletown, CT 06457

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of State Agency Reportable Events website identified the allegation was reported to the State Agency on 1/9/2025, five (5) days after the incident occurred. Interview with RN #1 was not obtained during the survey. Interview with the DON on 1/30/2025 at 1:45 PM identified that on 1/9/2025 she received a call from the supervisor indicating NA #1 had expressed concerns about Resident #1 yelling out, she punched me in the face, and during the investigation NA #1 identified that this occurred on 1/4/2025 (five days prior). The DON stated the incident should have been reported on 1/4/2025 when it occurred. Review of facility Abuse Policy & Procedure Policy directed in part, abuse allegations require immediate reporting to the supervisor. Facility documentation review identified staff education was initiated on 1/10/2025 regarding Abuse and Resident Rights policies and reporting of abuse timely. A QAPI meeting was held on 1/24/2025 and audits were initiated 12/1/2024. Based on review of facility documentation, past non-compliance was identified as of 1/24/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure care was provided in accordance with the resident plan of care. The findings include: Resident #1's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment, was dependent for ADLs, and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 9/10/2024 identified Resident #1 had deficit in self-care function related to impaired mobility, limited functional ability, cognitive deficit and incontinence. Interventions directed assist of two (2) for bed mobility, bed level rolling, turned, repositioned slowly assisted by two (2) staff members while reassuring the resident he/she is safe bathing, dressing, transfers, and mechanical lift for transfers. Nurse aide care card directed two (2) staff for care. Nursing note written by RN #1 on 1/4/2025 at 9:31 AM identified Resident #1 sustained a left eye bruise and cut from Hoyer lift sling attachment. Resident #1 reportedly had been agitated and banged his/her head on the pillow and then the device. The area was cleansed, and one steri-strip was applied. The MD and responsible party notified were notified, and the plan of care was updated to direct the sling was not to be attached until Resident #1 was ready for immediate transfer. Interview, review of facility documentation on 1/30/2025 at 11:08 AM with NA #1 identified that when on 1/4/2025 she heard the resident yell, NA #2 was the only aide in the room at the time. NA #1 indicated that the Hoyer lift was not yet in the room and once she returned with the Hoyer, they got the resident up using the Hoyer lift and when Resident #1 was out of bed, NA #1 saw the discoloration to the resident's eye. Interview and record review with NA #2 on 1/30/2025 at 11:19 AM identified on 1/4/2025 Resident #1 was agitated, and when she returned to provide care, Resident #1 stated ow, my eye. NA #2 stated she could not recall what position the resident was in while in the bed and indicated that she was providing care alone as she typically does prior to calling for help with the Hoyer transfer. NA #2 stated the resident care card directed the assistance of two (2) staff with care, and it takes too long sometimes to get help, so she provided the care by herself. Then she asked for help with the transfer. NA #2 stated she should not have provided care alone and she should not have provided care while the resident was yelling. Interview with the DON on 1/30/2025 at 1:45 PM identified Resident #1 had a history of combative behaviors and was care planned for two (2) staff assist with care, and NA #2 should not have provided care alone. The DON further stated, if Resident #1 was agitated when NA #2 approached the resident for care, NA #2 should not have provided care at that time. Facility documentation review identified staff education was initiated on 1/10/2025 regarding providing the correct level of assistance per the [NAME] (plan of care). Audits were initiated 1/10/2025 and a QAPI meeting was held on 1/24/2025. Based on review of facility documentation, past non-compliance was identified as of 1/24/2025.