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	07/30/2025

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 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 review of the clinical record and facility documentation, and interviews for one (1) of two (2) residents (Resident #2) reviewed for medication errors, the facility failed to ensure a physician order was transcribed correctly, and failed to ensure the resident was free from a medication error. The findings include: Resident #2's diagnoses included atrial fibrillation (fast irregular heart rate). Hospital Discharge summary dated [DATE] directed Resident #2 was to receive Aspirin 81 milligrams (mg) by mouth two times a week. The Nursing admission Evaluation dated 4/19/2025 identified Resident #2 was alert and oriented, and was on anticoagulant medication (a blood thinner preventing blood clots). The Resident Care Plan (RCP) dated 4/19/2025 identified a potential for adverse effects due to anticoagulant therapy. Interventions administer medications as ordered. Nursing note dated 4/19/2025 at 6:07 PM written by RN #3 identified the physician was upadted and orders were verified. A physician order dated 4/19/2025 directed to administer Aspirin oral tablet 81 mg once daily for antiplatelet therapy (prevent blood clots) starting on 4/21/2025. Additional reivew identified the order was transcribed and entered into the electronic medical record (EMR) by RN #2. Review of the April 2025 Medication Administration Record (MAR) identified Aspirin 81 mg was administered daily at 9:00 AM from 4/21 through 4/25/2025 (5 days). Record review identified Resident #2 was discharged from the facility on 4/25/2025. Facility Medication Incident Report dated 5/7/2025 identified a medication error for Resident #2 was discovered at 9 AM. Resident #2 was given Aspirin once a day, and the order was for the Aspirin to be given twice a week. The form indicated the error was a transcription error. Interview with RN #2 on 7/28/2025 at 2:18 PM identified she transcribed the physician order for Aspirin from the hospital discharge summary on 4/20/2025, and stated she must have read the order wrong, and she did not re-check the order before confirming it in the EMR. RN #2 identified she when the error occurred and she thought her preceptor/RN #3 would have checked her work. Interview with RN #3 on 7/28/2025 at 2:41 PM identified on 4/19/2025 she was orienting RN #2 and she did not check the physician orders for accuracy when they were transcribed by RN #2. RN #3 stated that when RN #2 entered (acknowledged) the physician order, she also confirmed the order in the EMR, and it did not display for RN #3 to review the order to ensure it was accurate. RN #3 stated that since she was orienting RN #2, she should have checked RN #2's work and verified the orders. Interview with the DNS on 7/28/2025 at 2:56 PM identified nurses are expected to reconcile hospital orders with the physician, transcribe the orders into the EMR and then acknowledge that the orders are correct. She reported that once the orders are acknowledged in the EMR the orders show as pending confirmation and a second nurse is responsible to review them for accuracy. The second nurse would then confirm the orders in the EMR and they would then be listed in the MAR. The DNS stated a second check was not completed, resulting in the medication error. Facility documentation review identified staff education was initiated on 5/12/2025 and included review of transcription of physician orders and medication reconciliation. A a QAPI meeting was held on 5/13/2025 and audits were initiated on 5/30/2025. Based on review of facility documentation, past non-compliance was identified.

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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(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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure care was provided in accordance with the plan of care. The failure resulted in a fall with injury. The findings include: Resident #1's diagnoses included cerebral infarction (stroke) and morbid obesity. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and was dependent on staff for bed mobility and transfers. The Resident Care Plan (RCP) dated 4/16/2025 identified that Resident #1 a deficit related to deconditioning and weakness. Interventions directed side-rails to assist with bed mobility, and two (2) staff for assistance personal hygiene, and turning and repositioning in bed. Facility reportable event dated 6/27/2025 at 8:15 AM identified Resident #1 had severe cognitive impairment, and required assist of two (2) for activities of daily living (ADLs) and bed level rolling. The report identified Nurse Aide (NA) #1 witnessed Resident #1 roll out of bed. Right knee pain and swelling were noted, the provider was notified and new orders obtained for x-rays, with positive results for a right femur fracture and Resident #1 was sent to the hospital. The facility incident summary dated 7/3/2025 identified NA #1 reported that Resident #1 rolled out of bed to his/her left side after feeling confused when the aide instructed him/her to roll towards me. Instead, Resident #1 rolled the opposite way with the use of the partial bed rails, and fell out of the bed. A nurse's note dated 6/27/2025 at 9:13 AM identified while NA #1 was giving personal care and attempted to change the bed linens, NA #1 asked Resident #1 to turn onto his/her left side. Resident #1 rolled too far and subsequently fell out of the bed. APRN note dated 6/27/2025 at 10:00 AM identified Resident #1 was seen after a fall with right knee pain. Resident #1 complained of significant right knee pain, had swelling with tenderness and an abrasion (scrape) and decreased range of motion. A STAT (immediate) x-ray was ordered to rule out a fracture. X-ray results dated 6/27/2025 identified a displaced fracture of the distal femur (fractured ends of the thigh bone near the knee that have shifted out of alignment). Nursing change in condition note dated 6/28/2025 at 5:40 AM identified x-ray results indicated a right distal femur fracture (just above the knee joint). The provider was notified, and Resident #1 was transferred to the hospital for evaluation. Review of hospital documentation identified that Resident #1 was admitted for a fracture of the right distal femur. Resident #1 had a right femur Open Reduction and Interval Fixation (ORIF - surgical procedure to stabilize the femur near the knee joint) on 6/28/2025. Record review identified Resident #1 was readmitted to the facility on [DATE] with orders for touch-down-weight bearing right leg, with a knee immobilizer, and orthopedic follow up in two (2) weeks. Orthopedic visit note dated 7/14/2025 identified staples were removed, directed start Physical Therapy (PT) for range of motion and follow up in two (2) to four (4) weeks. Interview with NA #1 on 7/28/2025 at 11:11 AM identified on 6/27/2025 when she provided incontinent care for Resident #1, she requested Resident #1 turn towards her onto his/her right side and grab onto the side-rail. NA #1 stated that instead of turning to the right side as requested, Resident #1 grabbed onto the left side-rail and turned to the left and slid off the bed onto the floor landing on his/her right side. NA #1 stated she was unsure how the fall actually happened, or which leg went over the side of the bed first because it happened so quickly. NA #1 stated she had provided care for Resident #1 for the past two (2) years, but she never looked at the resident's Kardex/NA Care Card and she did not know Resident #1 required two (2) staff for bed-level care and turning and repositioning in bed. Although NA #1 indicated she should have checked the NA Care Card for directions, she was unable to explain why she did not look at the NA Care Card prior to providing care. Interview with PT #1 and Speech Therapist (ST) #1 on 7/28/2025 at 11:59 AM identified that Resident #1 was discharged from PT services on 6/19/2025 (8 days prior to the fall), and required two (2) staff for ADLs and bed mobility for safety. Interview with the DNS on 7/28/2025 at 10:10 AM identified the Kardex/NA Care Card directed two (2) staff for assistance with bed-level care and bed mobility, and NA #1 provided the care without a second staff member to assist. The DNS stated NA #1 did not request assistance from other staff when she provided care and when she asked Resident #1 to turn in the bed. The DNS indicated NA #1 should have had another staff member to assist with the care and she expected all staff to review the Kardex/NA Care Card for a resident prior to providing care. Although requested, the Kardex/NA Care Card for Resident #1 prior to the fall was not provided during the survey. Facility documentation review identified staff education was initiated on 6/27/2025 and included NAs must check the Kardex (NA Care Card) before providing care to a resident, and