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	03/05/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and staff interviews for one (1) of two (2) residents (Resident #1) reviewed for accidents, the facility failed to develop a comprehensive, person-centered care plan to address a cognitively impaired resident's toileting needs and fall risk, including the absence of a scheduled toileting or prompted voiding program. The findings include:Resident #1 was admitted to the facility with diagnoses that included osteoarthritis of the knee, anxiety and Alzheimer's dementia. Resident #1 had a conservator of person and estate.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had impaired cognition (Brief Interview for Mental Status (BIMS) score of 5), was frequently incontinent of bowel and bladder and was not currently on a toileting program.The Resident Care Plan (RCP) dated 12/2/25 identified Resident #1 had a deficit in self-care function related to weakness and deconditioning. Interventions included toileting with a straight point cane with a supervise/touching assist of one (1) staff (helper gives verbal cues or touch assist) and personal hygiene with a supervise/touching assist of one (1) staff. The RCP identified Resident #1 had Dementia with interventions that included to anticipate and meet needs. The RCP further identified Resident #1 had a potential for fall due to unsteady gait with interventions that included non-skid socks at all times and in bed, note any changes in gait and report as needed and offer diversional activities such as music, snack, toileting and ambulating.Review of the RCP failed to identify a scheduled toileting or prompted voiding program to address incontinence and toileting needs.The Reportable Event form dated 1/25/26 at 10:30 AM identified Resident #1 had an unwitnessed fall with a head strike that caused a hematoma of Resident #1's frontal head and a painful right forearm. Resident #1 was sent to the emergency department (ED) for an evaluation.A statement by NA #1 dated 1/25/26 identified he opened the bathroom door for Resident #1 and Resident #1 put his/her cane in the sink. NA #1 turned away slightly and closed the door a little to give Resident #1 privacy. NA #1 heard a sound, turned around, and saw Resident #1 on the floor lying on his/her back.Review of the ED visit dated 1/25/26 identified Resident #1 was diagnosed with a bicondylar intra-articular fracture of the distal humerus. Resident #1 had new orders to maintain a sling and follow up in one (1) to two (2) weeks.The RCP was updated on 1/26/26 with an intervention to keep hands on Resident #1 at all times when assisting Resident #1 with bathroom needs until further notice and cleared by therapy team.A nursing note dated 1/29/26 at 2:40 PM identified Resident #1 was noncompliant with transfers. Resident #1 was noted in the bathroom after asking to lay down.The RCP was updated on 1/30/26 with the interventions to attempt to keep Resident #1 entertained in the common area as tolerated for monitoring, CBC/CMP, orthostatic blood pressure monitoring and every fifteen (15) minute checks when Resident #1 was in the bathroom.A nursing note dated 1/31/26 at 2:33 PM identified Resident #1 continued with every fifteen (15) minute checks while in the room.A nursing note dated 2/10//26 at 9:09 PM identified Resident #1 was observed multiple times ambulating without assistance and not using the call light.The nursing note dated 2/14/26 at 12:45 AM identified Resident #1 was observed lying on the bathroom floor on his/her left side at 12:45 AM. Resident #1 stated he/she was using the bathroom. Resident #1 complained of (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severe pain to the left upper extremity, was unable to move the left upper arm due to pain and 911 was called for hospital transfer.Review of the ED visit dated 2/14/26 identified Resident #1 was diagnosed with a left displaced comminuted fracture of the distal humerus.Interview with NA #1 on 3/5/26 at 12:15 PM identified on 1/25/26 at 10:30 AM he assisted Resident #1 to the bathroom to wash his/her hands. He identified Resident #1 ambulated with a cane and once in the bathroom, Resident #1 put the cane on the sink. He identified Resident #1 liked privacy when in the bathroom, so he closed the door but left it slightly open and turned around in the other direction. He identified he then heard a sound, turned around, and saw Resident #1 on the floor.Interview with the DNS on 3/5/36 at 1:45 PM identified at the time of the first fall, Resident #1 was a supervised assist of one with personal hygiene and toileting. She identified a supervised assist meant staff were to supervise Resident #1 with the Activity of Daily Living (ADL) to allow for queuing and assistance if needed. She identified the NA did not have constant supervision because his back was turned.Review of the ADL policy identified that ADL's are essential tasks that each person needs to perform, on a regular basis, to sustain basic survival and well-being. Staff are to provide assistance to complete ADL activities per the person-centered evaluation and care plan.Review of the Fall Prevention Program directed for resident review of risk factors and develop interventions and incorporate them into the Resident Care Plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide adequate supervision and implement effective fall prevention interventions for a cognitively impaired resident with incontinence and a known fall risk, resulting in two (2) unwitnessed falls with major injuries (right and left humerus fractures). The findings include:Resident #1 was admitted to the facility with diagnoses that included osteoarthritis of the knee, anxiety and Alzheimer's dementia. Resident #1 had a conservator of person and estate.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had impaired cognition (Brief Interview for Mental Status (BIMS) score of 5), was frequently incontinent of bowel and bladder and was not currently on a toileting program.The Resident Care Plan (RCP) dated 12/2/25 identified Resident #1 had a deficit in self-care function related to weakness and deconditioning. Interventions included toileting with a straight point cane with a supervise/touching assist of one (1) staff (helper gives verbal cues or touch assist) and personal hygiene with a supervise/touching assist of one (1) staff. The RCP identified Resident #1 had Dementia with interventions that included to anticipate and meet needs. The RCP further identified Resident #1 had a potential for fall due to unsteady gait with interventions that included non-skid socks at all times and in bed, note any changes in gait and report as needed and offer diversional activities such as music, snack, toileting and ambulating.Review of the clinical record failed to identify a scheduled toileting or prompted voiding program to address incontinence and toileting needs.The Reportable Event form dated 1/25/26 at 10:30 AM identified Resident #1 had an unwitnessed fall with a head strike that caused a hematoma of Resident #1's frontal head and a painful right forearm. Resident #1 was sent to the emergency department (ED) for an evaluation.A statement by NA #1 dated 1/25/26 identified he opened the bathroom door for Resident #1 and Resident #1 put his/her cane in the sink. NA #1 turned away slightly and closed the door a little to give Resident #1 privacy. NA #1 heard a sound, turned around, and saw Resident #1 on the floor lying on his/her back.Review of the ED visit dated 1/25/26 identified Resident #1 was diagnosed with a bicondylar intra-articular fracture of the distal humerus. Resident #1 had new orders to maintain a sling and follow up in one (1) to two (2) weeks.Physician's orders dated 1/26/26 directed non-weight baring to the right upper extremity, ensure right arm sling is in place and arm elevated and Tylenol 325 mg two tablets every eight hours as needed for pain.The RCP was updated on 1/26/26 with an intervention to keep hands on Resident #1 at all times when assisting Resident #1 with bathroom needs until further notice and cleared by therapy team.A nursing note dated 1/29/26 at 2:40 PM identified Resident #1 was noncompliant with transfers. Resident #1 was noted in the bathroom after asking to lay down.The RCP was updated on 1/30/26 with the interventions to attempt to keep Resident #1 entertained in the common area as tolerated for monitoring, CBC/CMP, orthostatic blood pressure monitoring and every fifteen (15) minute checks when Resident #1 was in the bathroom.A nursing note dated 1/31/26 at 2:33 PM identified Resident #1 continued with every fifteen (15) minute checks while in the room.A nursing note dated 2/10//26 at 9:09 PM identified Resident #1 was observed multiple times ambulating without assistance and not using the call light.The nursing note dated 2/14/26 at 12:45 AM identified Resident #1 was observed lying on the bathroom floor on his/her left side at 12:45 AM. Resident #1 stated he/she was using the bathroom. Resident #1 complained of severe pain to the left upper extremity, was unable to move the left upper arm due to pain and 911 was called for hospital transfer.Review of the ED visit dated 2/14/26 identified Resident #1 was diagnosed with a left displaced comminuted fracture of the distal humerus.Interview with NA #1 on 3/5/26 at 12:15 PM identified on 1/25/26 at 10:30 AM he assisted Resident #1 to the bathroom to wash his/her hands. He identified Resident #1 ambulated with a cane and once in the bathroom, Resident #1 put the cane on the sink. He identified Resident #1 liked privacy when in the bathroom, so he closed the door but left it slightly open and turned around in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	other direction. He identified he then heard a sound, turned around, and saw Resident #1 on the floor.Interview with the DNS on 3/5/36 at 1:45 PM identified at the time of the first fall, Resident #1 was a supervised assist of one with personal hygiene and toileting. She identified a supervised assist meant staff were to supervise Resident #1 with the Activity of Daily Living (ADL) to allow for queuing and assistance if needed. She identified the NA did not have constant supervision because his back was turned.Review of the ADL policy identified that ADL's are essential tasks that each person needs to perform, on a regular basis, to sustain basic survival and well-being. Staff are to provide assistance to complete ADL activities per the person-centered evaluation and care plan.Review of the Fall Prevention Program directed for resident review of risk factors and develop interventions and incorporate them into the Resident Care Plan. The facility presented a corrective action plan for past non compliance dated 1/30/26 which included:A facility wide audit to identify cognitively impaired residents.Staff education for following the plan of care and what was required for supervision with ADLs.Care observation audits to ensure plans of care were implemented.The corrective action plan was reviewed during QAPI on 2/26/26 The corrective action plan was accepted by the state agency during an onsite visit on 3/5/26.