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	03/25/2026

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 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 review of the clinical record, facility documentation, facility policy, and interview for 1 of 3 residents (Resident #125) reviewed for medication administration, the facility failed to ensure the resident was free from a significant medication error. The findings included:Resident #125 was admitted to the facility in July 2025 with diagnoses that included nontraumatic intracerebral hemorrhage in brain stem, chronic respiratory failure, and congestive heart failure.Review of physician's orders dated 11/5/25 through 12/31/25 directed to apply Fentanyl (opioid pain medication) 12 mcg patch, 1 patch transdermal every 72 hours for pain and remove per schedule. Review of the controlled substance disposition records dated 11/5/25 through 12/31/25 identified the pharmacy dispensed Fentanyl 12 mcg patches which were applied/removed to Resident #125 every 72 hours. The quarterly MDS dated [DATE] identified Resident #125 had severely impaired cognition and was not on oxygen. The MDS failed to identify the resident was receiving opioid medication. The care plan dated 1/28/26 identified Resident #125 had actual pain relating to disease process. Interventions included administering medication as ordered. Anticipate the need for pain relief and respond immediately to any complaint of pain. Monitor and report to the nurse any signs and symptoms of non-verbal pain. Further, Resident #125 had altered respiratory status and difficulty breathing related to chronic respiratory failure. Interventions included to administer medications as ordered, monitor for effectiveness and side effects, and elevate the head of bed 30-45 degrees to facilitate ease of breathing.Review of physician's orders dated 1/1/26 through 2/12/26 directed to administer Fentanyl 12 mcg patch, apply 1 patch transdermal every 72 hours for pain and remove per schedule. Review of the controlled substance disposition records identified the pharmacy dispensed 1 Fentanyl 12 mcg patches on 2/3/26.Review of the controlled substance disposition record identified the pharmacy dispensed 5 Fentanyl 12 mcg patches on 2/10/26, (15-day supply). Subsequent to LPN #11 removing the Fentanyl 12 mcg patch one day early in error on 2/13/26, RN #8 obtained a verbal order from APRN #4 to replace the Fentanyl patch. RN #8 transcribed the verbal order as follows; apply Fentanyl 75 mcg patch, apply one patch transdermal every 72 hours for pain. Apply new patch on 2/13/26 and next patch is due on 2/16/26, remove per schedule.Review of the controlled substance disposition records through 2/27/26 identified no Fentanyl 75 mcg patches had been delivered. Further, the controlled substance disposition records identified Fentanyl 12 mcg patches were applied to Resident #125 on 2/13/26, 2/16/26, 2/19/26, 2/22/26, and 2/25/26.Review of the February 2026 MAR dated 2/13/26 - 2/27/26 identified although Fentanyl patch 75 mcg had not been delivered, nursing staff were signing that they applied Fentanyl patch 75 mcg to Resident #125 on 2/13/26, 2/16/26, 2/19/26, 2/22/26, and 2/25/26. APRN #4 entered an order dated 2/27/26 to apply Fentanyl 75 mcg patch, one patch transdermal every 72 hours for pain and remove per schedule.Review of the controlled substance disposition record for the Fentanyl 75 mcg dated 2/28/26 identified the pharmacy dispensed 10 patches and the first 75mcg patch was applied on 2/28/26 at 1:24 PM. Review of the February 2026 MAR identified Fentanyl 75 mcg patch was applied on 2/28/26 at 1:24 PM. The SBAR (Situation, Background, Assessment, Recommendation; a crucial communication technique in healthcare that helps health professionals communicate clear elements of a patient's condition) dated 3/1/26 at (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:32 PM identified the following. Resident #125 experienced a change in condition, including a decrease respiratory rate of 9 breaths per minute (normal respiratory rate is 12 - 20 breaths per minute), oxygen saturation 86% on room air (normal is 95 - 100%), which improved to 96% following elevation of head of bed, repositioning, and administration of oxygen via nasal cannula. Subsequently, Resident #125 was alert, with no change in mental status, and responded appropriately to questions and directions. The reportable event form dated 3/1/26 at 1:30 PM identified Resident #125 received Fentanyl 75 mcg patch, an error of clinical significance, due to a transcription error. The Fentanyl patch was removed and Resident #125 was assessed and monitored, with vital signs obtained. Resident #125 was alert with confusion. Physician's orders included to hold Oxycodone and Xanax for 24 hours. The nurse's note dated 3/1/26 at 2:51 PM identified Person #1 approached LPN #15 expressing concern about Resident #125's respiratory status. LPN #15 immediately assessed Resident #125 and observed a respiratory rate of 9 breaths per minute and oxygen saturation 86% on room air. Resident #125 was repositioned with the head of the bed elevated, and supplemental oxygen was administered at 3 liters via nasal cannula. APRN #4 was notified and ordered the removal of the Fentanyl patch and a hold on Xanax and Oxycodone for 24 hours. Monitor vital signs every 15 minutes for the first hour, then every 30 minutes for the following 4 hours. Resident #125 remained alert and verbally responsive. MD #1 (Medical Director) was notified. Reported vital signs 116/80, 73, respiration rate 10. MD #1 ordered the resident to continue oxygen via nasal cannula and obtain vital signs every 30 minutes until 6:00 PM, with updates to be reported to MD #1.A written statement by APRN #4 dated 3/2/26 at 4:33 PM indicated that on Friday 2/27/26 she refilled a prescription for a Fentanyl patch. APRN #4 indicated she did not recognize that the resident's Fentanyl dosage had been increased in error to Fentanyl 75 mcg. APRN #4 indicated she intended to refill Fentanyl 12 mcg patch; however, she accidentally refilled the prescription for Fentanyl 75 mcg. APRN #4 indicated record review identified Resident #125 received Fentanyl 75 mcg Patch on 2/28/26, and subsequently on Sunday 3/1/26, Resident #125 exhibited respiratory depression and mild hypoxia. APRN #4 indicated she was notified, and the Fentanyl 75 mcg patch was discontinued, the prn narcotics were held, and Resident #125 was provided supplemental oxygen. Resident #125 was monitored for 24 hours without further adverse effects. APRN #4 indicated she evaluated Resident #125 the next day on 3/2/26 and the resident had returned to baseline and no longer required supplemental oxygen. A plan to restart his/her usual Fentanyl 12 mcg patch on 3/3/26.A written statement by LPN #11 (agency) dated 3/3/26 at 5:16 PM identified that she was the assigned nurse to Resident #125 on 2/13/26 during the 7:00 AM - 3:00 PM shift. LPN #11 indicated there was an order to remove Fentanyl 12 mcg patch. LPN #11 indicated after removing the Fentanyl patch (mcg strength not noted), she realized there was no order to replace the patch. LPN #11 indicated she notified RN #8 (RN Supervisor). LPN #11 indicated that RN #8 notified the APRN of the 12 mcg patch removal. LPN #11 indicated the APRN approved replacement of the Fentanyl 12 mcg patch and the order to reflect the 3 days cycle. LPN #11 indicated that RN #8 entered the updated order. LPN #11 indicated she replaced the Fentanyl 12 mcg patch as instructed and documented the occurrence, including the updated schedule. LPN #11 indicated she notified the oncoming nurse of the discrepancy and informed him of the revised application and removal schedule.A written statement by RN #8 dated 3/3/26 (no time) indicated she worked on 2/13/26 during the 7:00 AM - 3:00 PM shift and LPN #11 (agency nurse) came to her with a Fentanyl patch that she took off to waste with another nurse so she could reapply today. RN #8 indicated she reviewed the MAR which directed the Fentanyl 12 mcg patch to be changed on 2/14/26, not 2/13/26. RN #8 indicated she notified the APRN and received a telephone order to change the patch on 2/13/26 and continue every 72 hours. RN #8 identified she signed onto the computer and entered a Fentanyl patch order for what she thought was a 12 mcg patch, however, she inadvertently selected and entered an order for Fentanyl 75 mcg instead of 12 mcg. RN #8 indicated she co-signed the order herself rather than obtaining a second nurse to verify the order. RN #8 indicated she was unaware at the time that the incorrect dosage had been entered.The summary (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report dated 3/9/26 identified that on 3/1/26 a medication dose discrepancy involving a Fentanyl patch was identified for Resident #125. The patch in place was Fentanyl 75 mcg, while the intended order was for Fentanyl 12 mcg. The Fentanyl patch 75 mcg was immediately removed upon identification, and Resident #125 was promptly assessed by the RN supervisor. Resident #125 experienced a brief episode of oxygen desaturation, which was addressed with repositioning, supplemental oxygen, and ongoing monitoring. Resident #125 was stabilized and remained in the facility without the need for emergency transfer or Naloxone administration. After a thorough investigation it was determined that the discrepancy occurred during medication order entry following a provider order update, resulting in an incorrect dose being reflected in the electronic record. The facility initiated an internal review, notified the provider, conducted a root cause analysis, and implemented corrective measures, including reinforcement of medication order entry, transcription verification, and medication safety practices, additional staff education, implementation of two-nurses verification for Fentanyl patch application, and on-going medication safety audits through the facility's Quality Assurance and Performance Improvement (QAPI) process. A facility-wide review of medication records, physician's orders, and controlled substance documentation was conducted to verify that narcotic medications were accurately ordered, transcribed, and administered according to provider orders. Education was provided to the nursing staff, with reinforcement of facility policies related to medication administration, medication order entry, transcription verification, and controlled substance management. The facility implemented two-nurses verification for Fentanyl patch application and documentation to ensure the correct narcotic medication and dose are applied. Interview with the DNS on 3/22/26 at 1:00 PM identified she was not aware that the Fentanyl patch was transcribed incorrectly on 2/13/26 and the resident received a dose of 75 mcg on 2/28/26 until 3/1/26, when Resident #125 experienced a change in condition. The DNS indicated Resident #125 had a Fentanyl 75 mcg patch applied on 2/28/26, while the intended dose was Fentanyl 12 mcg. The DNS indicated upon identification of the discrepancy, the Fentanyl 75 mcg patch was immediately removed, and Resident #125 was promptly assessed by the RN supervisor. The DNS indicated the licensed nurse failed to follow the six rights of medication administration prior to administration of medication. Interview with APRN #4 on 3/26/26 at 11:16 AM identified on Friday 2/27/26 she refilled a prescription for a Fentanyl patch. APRN #4 indicated she did not recognize that the resident's Fentanyl dosage had previously been increased in error on 2/13/26 to Fentanyl 75 mcg patch. APRN #4 indicated she intended to refill Fentanyl 12 mcg patch; however, she accidentally refilled the prescription for Fentanyl 75 mcg patch. APRN #4 indicated the facility had notified her of a change in condition of Resident #125 on 3/1/26, that Resident #125 exhibited respiratory depression and mild hypoxia. APRN #4 indicated she was notified, and the Fentanyl 75 mcg patch was discontinued. APRN #4 indicated that prn narcotics were held, and Resident #125 was provided supplemental oxygen with good effects and vital signs remained stable. APRN #4 indicated per nursing Resident #125 remained alert and conversive throughout the day. APRN #4 indicated she evaluated Resident #125 the next day on 3/2/26 alert and back to baseline. APRN #4 indicated that the licensed nurse should have transcribed the medication correctly, followed the medication administration policy, and followed the six rights of medication administration.Interview with Pharmacist #1 on 3/26/26 at 11:28 AM identified the first delivery of Fentanyl 75 mcg patch to the facility occurred on 2/28/26 at 3:33 AM, following receiving an order for Fentanyl 75 mcg patch on 2/27/26. Pharmacist #1 indicated the pharmacy had only been dispensing Fentanyl 12 mcg patches prior to 2/28/26. After the Fentanyl 75 mcg was discontinued, a new order for Fentanyl 12 mcg patch was received on 3/1/26 and delivered to the facility on 3/1/26 at 9:55 PM.Interview with RN #8 on 3/27/26 at 2:21 PM identified she was the RN supervisor 2/13/26 during the 7:00 AM - 3:00 PM shift, when LPN #11 (agency nurse) presented her with a Fentanyl patch removed from Resident #125, indicating it needed to be destroyed and replaced. RN #8 indicated she could not recall all the details of the event but had previously provided a written statement. RN #8 indicated she entered a new order into the eMAR; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however, she inadvertently selected and entered an order for Fentanyl 75 mcg instead of 12 mcg. RN #8 indicated she failed to read the complete order prior to entry. RN #8 indicated she co-signed the order herself rather than obtaining a second nurse to verify the order, in accordance with safe practice. RN #8 indicated she was unaware the incorrect dose had been entered at the time and she indicated she had made a mistake. RN #8 indicated the facility had conducted an investigation which identified that the incorrect Fentanyl 75 mcg order had been entered into the eMAR by her. RN #8 indicated subsequent nursing staff signed off on the incorrect eMAR order for Fentanly 75 mcg patch; however, they were administering Fentanyl 12 mcg patches on Resident #125. RN #8 indicated that the medication administered did not match the physician's order as documented in the eMAR. RN #8 indicated that nursing staff failed to fully read and verify the physician's order against the medication packaging and did not adhere to the facility's policy regarding the 6 rights of medication administration. Although attempted, an interview with MD #1, LPN #9, LPN #10, LPN #11, LPN #12, LPN #14, and LPN #15 were not obtained. Review of the facility transcription of orders policy identified the purpose is to establish requirements for accepting, transcribing, and reviewing orders. Orders can be obtained over the phone. Transcribing is the recording of orders by a RN, LPN or by clerical/non-licensed unit clerk with appropriate training and competency per state regulations. A RN or LPN must review and verify accuracy and sign off orders transcribed by a non-licensed unit clerk or Med Tech. Review of the facility handling of Fentanyl patches policy identified Fentanyl patches shall be handled in such a manner as to minimize potential for diversion or abuse. Upon applying a new patch to a resident's skin, licensed staff shall indicate date, time, and initials directly on the patch in pen or magic marker and inspect each patch every shift. Upon removal from a resident's skin, another licensed nurse signature and countersignature of disposal shall be noted on resident's MAR.Review of the facility medication pass policy identified that medications are administered safely and timely per the physician's orders. Remember the six (6) rights of medication pass: Right resident, right drug, right dose, right route, right time, and right dosage form. The policy failed to reflect documentation regarding the three (3) checks of medication administration.Review of the facility medication error policy identified that residents are to remain free from complications of medication errors. Medication errors are monitored and the facility has a process specific to medication errors that will be used for measuring inconsistencies. The policy will be used to identify opportunities for improvement in accordance with QAPI. To monitor resident outcomes related to medication errors and provide necessary following actions to correct the problem and/or avoid recurrence. Medication error is a discrepancy between what the healthcare provider ordered and what the resident received. Significant medication errors mean one that causes an adverse effect to the residents, i.e. discomfort or jeopardized his or her health and safety.