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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation for 1 of 5 residents reviewed for abuse (Resident #22), the facility failed to protect the resident from repeated nonˆconsensual physical/sexual contact by another resident (Resident #129) despite a known history of prior sexual abuse between the same residents. The facility failed to implement required safety interventions, ensure effective 1:1 supervision, separate the residents as careˆplanned, or follow its Abuse and Sexual Interaction policies, resulting in actual harm to Resident #22. Resident #129, who had a documented history of sexually inappropriate contact toward Resident #22, again made nonˆconsensual physical contact by grabbing the resident's chest/shirt area while under 1:1 supervision, and the facility did not complete a Reportable Event Form or document the incident in Resident #22's medical record. Despite a careˆplan directive to move Resident #22 to another unit for safety, the residents remained on the same unit with repeated exposure, and staff failed to immediately report the incident to the DNS, administrator, or provider as required. Inconsistent staff accounts and the lack of documentation impeded an appropriate investigation, and Resident #22 reported feeling uncomfortable, with a psychiatric provider identifying the potential for negative psychological impact from repeated exposure to the resident who previously sexually mistreated him/her. The findings include:a. Resident #22 was admitted in October 2024 with diagnoses that included anoxic brain damage and dementia.The quarterly MDS dated [DATE] identified Resident #22 had severely impaired cognition and required one person assist with locomotion with the use of a manual wheelchair.The care plan dated 1/22/25 identified Resident #22 had a behavior problem that included anxiety and aggression towards others. Interventions included monitoring behavior and administering medications as ordered. b. Resident #129 was admitted in August 2023 with diagnoses that included schizophrenia and dementia.The quarterly MDS dated [DATE] identified Resident #129 had moderately impaired cognition and was independent with ambulation.The care plan dated 1/7/25 identified Resident #129 had a mood problem related to schizophrenia and a history of elopement with wandering behaviors. Interventions include monitoring and reporting changes in mood patterns and offer diversional activities if wandering.A Reportable Event Form dated 3/19/25 identified at 10:45 AM, Resident #22 was in a wheelchair self-propelling in the hall. Staff observed Resident #129 go behind Resident #22 and place his/her open left hand on Resident #22's left breast. Staff immediately intervened and separated the residents.For Resident #129, the care plan was revised to include immediate separation, psychiatric/social worker referral and indefinite 1:1 supervision on all shifts.For Resident #22, the care plan was revised to include immediate separation, move to an alternate wing and psychiatric/social worker referral.Although Resident #22's care plan indicated to move the resident to an alternate unit, the move was not completed, and Resident #129 and Resident #22 remained on the same unit.A Medical APRN progress note (Resident #129) dated 9/26/25 at 8:30 AM identified nursing reported Resident #129 with a history of inappropriate behaviors with indefinite 1:1 supervision, recently had an incident where he/she inappropriately touched another patient's body part (Resident #22). The nursing director is requesting further medical workup. Resident #129 was (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	unable to provide information or cooperate with instructions/boundaries regarding information or appropriate behaviors. Resident #129 was to be redirected as needed and continue 1:1 monitoring.A Psychiatric APRN progress note (Resident #129) dated 9/26/25 at 6:40 PM identified Resident #129 was evaluated for displaying sexually inappropriate behaviors per nursing. Resident #129 has a history of sexually inappropriate behaviors and under 1:1 staff supervision. Resident #129 was calm with no anxiety, denied any sexually inappropriate behaviors and was not a risk to self or others (inconsistent with documented repeated behavior). For Resident #22, a review of the clinical record identified no documentation regarding the incident and no completed reportable event form.Interview with the DNS on 3/24/26 at 1:53 PM identified she was unaware of the alleged incident and would have to further investigate the matter. Subsequently, the incident was reported.Interview with APRN #1 on 3/24/26 at 3:21 PM identified while reviewing the unit communication book on 9/26/25 she became aware of the incident involving Resident #129 who again, exhibited sexually inappropriate behaviors towards the same resident as he/she previously had in the past. APRN #1 indicated she was informed by (unidentified) nursing staff that prior to 9/26/25, Resident #22 had been sexually inappropriately touched by Resident #129 while under 1:1 staff supervision. APRN #1 indicated the incident involved Resident #129 grabbing Resident #22's left chest while passing in the hall and did not let go until 1:1 staff intervened and separated the two residents. APRN #1 spoke briefly to Resident #22 who reported while the breast was not touched, Resident #129 grabbed his/her chest causing him/her to feel uncomfortable. APRN #1 further identified Resident #129 was unusually confused during that time and received a medical workup to rule out potential underlying causes. Subsequent interview with the DNS on 3/24/26 at 3:34 PM identified she was aware of the alleged incident, but it was reported Resident #129 grabbed Resident #22's shirt, not the breast and was not threatening, therefore determined no further follow up was necessary (inconsistent staff reporting and contradicted by other accounts). Resident #129 subsequently received a medical workup and 1:1 supervision continued as ordered.Interview with NA #10 on 3/24/26 at 3:59 PM identified she was the assigned 1:1 staff during 3:00 PM to 11:00 PM on 9/25/26 and overnight 11:00 PM to 7:00 AM shift until 9/26/26. NA #10 indicated between 4:00 PM and 5:00 PM, she was walking down the hall with Resident #129. Resident #22 was approaching from the opposite direction. As they passed, with NA #10 positioned between them, Resident #129 reached out and grabbed Resident #22's shirt just above the breast holding it for approximately three seconds before NA #10 was able to separate the two. NA #10 indicated that although it did not appear Resident #129 was obviously aggressive or threatening, it was difficult to determine his/her state of mind or intent at the time of the incident. However, it was known Resident #129 had a prior history of sexual inappropriateness with Resident #22. NA #10 further identified there had been other occasions where Resident #129 had grabbed Resident #22's shirt in the past but the behavior was redirected and reported to nursing.Interview with APRN #3 (psychiatric) on 3/24/26 at 4:29 PM identified she was notified of sexually inappropriate behaviors by Resident #129 on 9/26/25 while reviewing the unit communication book used to report resident changes. The entry noted Resident #129 exhibited sexually inappropriate behaviors but did not specify it involved another resident. Resident #129 also engaged in self-stimulating sexual behaviors which at times were reported as inappropriate. APRN #3 indicated staff on duty were unable to provide details of the incident and there was no documentation in the clinical record. APRN #3 evaluated Resident #129 who had dementia and was unable to be interviewed. APRN #3 further identified no other incidents of inappropriate physical contact toward Resident #22 were reported since the initial incident (lack of nursing documentation of the event).Interview with MD #1, Medical Director on 3/25/26 at 1:29 PM identified he would expect the facility to follow policies related to abuse for any resident-to-resident incident, including those lacking the ability to consent. MD #1 indicated there was a lack of staff communication related to the incident and working with staff towards improvement.Subsequent interview with APRN #3 on 3/26/26 at 11:45 AM identified while there were no notable behavior changes requiring medication adjustments for Resident #22, repeated exposure to (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the same resident who sexually mistreated him/her in the past and continues to make physical contact, could have a negative psychological impact on the reasonable person over time.Review of the facility policy for Abuse directs every resident has the right to be free from abuse, including physical defined as hitting, pinching, slapping kicking, control through corporal punishment and sexual abuse defined as non-consensual contact of any type with a resident including sexual harassment, coercion, and sexual assault.Review of the facility policy for Sexual Interaction Between Residents directs for any sexual contact between residents unable to make an informed decision, attempt to separate and call for immediate assistance if unable, stay with the residents until the charge nurse/supervisor arrives to evaluate, initiate the abuse protocol, notify the administrator, DNS, health care provider, responsible parties, implement appropriate measures to keep residents safe and evaluate the residents for injury all of which will be documented.Attempts to interview RN #9, LPN #5, LPN #7, LPN #9, Resident #129 and Resident #22 were unsuccessful.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #43) reviewed for activities of daily living, the facility failed to ensure that the resident was treated in a dignified manner. The findings include:Resident #43 was admitted to the facility in October 2014 with diagnoses that included Alzheimer's disease, macular degeneration, and muscle weakness.The quarterly MDS dated [DATE] identified Resident #43 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff for assistance with toileting, bathing, and dressing.The care plan dated 3/18/26 identified Resident #43 had a self-care deficit due to Alzheimer's disease. Interventions included to provide the assistance of 2 staff members with showering/bathing.Observation on 3/23/26 beginning at 8:43 AM identified Resident #43 seated in a wheelchair in the hallway directly in front of the nurse's station on the 4th floor unit, with NA #2 brushing his/her hair. NA #2 was observed calling across the unit for NA #1 to look at Resident #43's hair, and NA #2 and NA #1 proceeded to move Resident #43 behind a keypad locked and unlabeled door directly behind them. At 8:45 AM upon entering the room. NA #2 was observed attempting to wet Resident #43's hair by wetting a hairbrush with water from a sink located in the room while NA #1 was observing. Resident #43 remained in his/her wheelchair and did not have any clothing protection in place. Interview with NA #2 immediately following this observation identified she observed feces in Resident #43's hair while attempting to brush it in the hallway. NA #2 identified she brought Resident #43 into the nurse aide stock room where the sink was located to use water to try to remove the feces. NA #2 identified she was unsure when Resident #43 last had a shower, and that she was not going to wash Resident #43's hair. NA #2 identified that, in her experience, there had been resident representatives on the unit who did not want the residents' hair washed due to oils in the hair but was unable to identify the specific residents. NA #2 was unable to identify if Resident #43's resident representative declined hair washing, or if Resident #43's resident representative would decline hair washing after feces was identified in Resident #43's hair.Observation at 9:00 AM identified NA #2 bringing Resident #43 out of the nurse aide stock room, positioning his/her wheelchair to the left of the room in the hallway, and leaving the area. Review of the clinical record failed to identify any documentation that the resident representative had directed staff not to wash Resident #43's hair. Interview with RN #4 (4th floor unit manager) on 3/23/26 at 9:10 AM identified that it was not acceptable for Resident #43 to not be offered or provided a shower following the identification of feces in his/her hair by NA #2. RN #4 identified that she would address the situation and provide education to NA #2 and ensure that Resident #43 was provided a shower.After surveyor inquiry, Resident #43 was provided in a shower on 3/23/26 at 11:00 AM.Review facility documentation dated 3/23/26 identified an in-servicing document for the 4th floor nursing staff. The in-service education identified that if a resident was noted to have stool, bodily fluid, or any other non-beneficial substance on their body, hair, or clothing, the resident was to be immediately offered or provided a shower unless refused. The document further identified that showers could be provided to a resident on any date or time and it did not need to be on their assigned shower day and all residents may be showered unless indicated by the nurse or care plan for a specific reason. The in-service education further identified that under no circumstances should bodily fluids be wiped away instead of washed clean. Further review of the documentation identified NA #2 signed the in-service attendance document, Interview with the DNS on 3/25/26 at 12:45 PM identified that it was not acceptable for any resident to not be provided with a shower following the identification of fecal matter in their hair. The DNS identified she was also not aware of issues on the 4th floor unit related to declining hair washing and believed that NA #2 provided this information in error. The facility policy on Resident Rights directed that all residents of the facility had the right to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be treated with consideration respect and full recognition of their dignity and individuality. The policy further directed that residents had the right to receive quality care and services with reasonable accommodations of their individual needs and preferences.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **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 resident (Resident #107) reviewed for rehabilitation, the facility failed to notify the physician that rehabilitation services were not provided according to specialty service recommendations. The findings include:Resident #107 was admitted in November 2025 with diagnoses that included nondisplaced fracture of the seventh cervical vertebra, and non-displaced fracture of the right tibia due to a motor vehicle accident.The admission MDS dated [DATE] identified Resident #A107 was cognitively intact, required two person assist with bed mobility, transfers, utilized a manual wheelchair with one assist for locomotion and was receiving occupational, physical and speech therapy.The care plan dated 11/7/25 identified Resident #107 had a fracture of the right tibia and cervical spine. Interventions included maintaining a cervical collar (neck collar) at all times, follow up with orthopedic consultations as indicated and provide occupational and physical therapy evaluation according to physician orders.Physical and Occupational Therapy Discharge Summaries dated 12/24/25 identified Resident #107 was independent bed mobility, sitting, standing and toileting with supervision/touch assist and refusing ambulation at the time. Resident #107 reached the highest functional level with continued level of function considered ?good' with consistent staff follow-through.Orthopedic consult (related to tibial fracture) dated 1/5/26 identified Resident #107 was evaluated for a tibial fracture and left hip dislocation. Recommendations included progressing to protected weight bearing status as tolerated, bilateral hip, knee and ankle range of motion (ROM) as tolerated with focus to the right knee ROM three times daily with aim of 0-90 degrees in the coming two weeks (2/9/26).An APRN progress note dated 1/5/26 identified Resident #107 returned from orthopedics with a referral for ambulatory rehabilitation services which have been reviewed and placed for scheduling. Referral indicates weight-bearing as tolerated to bilateral lower extremities, range of motion exercises bilateral hips, knees, ankles as tolerated, swelling and edema management, gait and balance exercises, and general body exercises requesting three days a week of physical therapy. Staff were to notify the provider of outpatient orthopedic consult results and any new orders for review.Physician orders dated 1/16/26, 11 days after orthopedic recommendations, directed Physical Therapy (PT) 3-5 days/week for 8 weeks.Physical Therapy evaluation dated 1/16/26 identified the continued need for services for strengthening, balance and toileting until 3/12/26.Physical Therapy Discharge summary dated [DATE] identified Resident #107 was deemed not safe to continue treatment due to non-compliance in wearing the cervical collar. Resident #107 was to continue mobility at wheelchair level until follow up appointment in February 2026 regarding any continued need for the cervical collar.Occupation Therapy Evaluation dated 1/23/26 identified therapy services were limited to evaluation only and were not continued due to non-compliance in the use of a cervical collar. Resident #107 was to follow up with orthopedics (for cervical collar) in 2/2026.Resident #107 was cleared by orthopedics for weight- bearing and was making excellent progress with physical therapy. The plan included continued OT/PT with weight bearing as cleared by orthopedics.Outpatient Rehabilitation consult dated 2/9/26 recommended OT and PT three times weekly for weight bearing, ROM and strengthening for the bilateral lower extremities.APRN progress note dated 2/10/26 at 11:31 AM identified ongoing rehabilitation after a right tibial plateau fracture. Resident #107 returned with ambulatory referral paperwork for outpatient rehabilitation services from orthopedics (for tibial fractur). Referral order reviewed and placed for scheduling today.APRN progress notes dated 2/11/26 through 2/19/26 identified Resident #107 was continuing to make progress in physical therapy and awaiting outpatient physical therapy.Orthopedic consult (for the cervical collar) dated 2/20/26 identified Resident #107's cervical collar was to be discontinued.APRN progress notes dated 2/20/26 through 3/3/26 identified Resident #107 was continuing to make progress in physical therapy and awaiting outpatient physical (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy.Neurology consult dated 3/4/26, 12 days post cervical collar discontinuation, identified Resident #107 needed rehabilitation therapy three times weekly for weight bearing and strengthening according to orthopedic recommendations.Interdisciplinary ?Secure Conversations' progress note dated 3/4/26 identified Resident #107 was recommended for physical therapy three times weekly following an orthopedic consult for weight bearing, ROM and strengthening for the bilateral lower extremities.Interdisciplinary ?Secure Conversations' progress note dated 3/5/26 identified #107 requested the physical therapy referral be sent to a community outpatient rehabilitation service and the referral was faxed.Resident #107 received the first evaluation for treatment on 3/13/26, twenty days post removal of the cervical collar.Interview with Resident #107 on 3/22/26 at 7:50 AM identified he/she was expected to begin outpatient physical therapy beginning sometime in January but was not seen until 3/13/26. Resident #107 indicated during a neurology consult on 3/4/26, providers inquired about rehabilitation services and were surprised to learn he/she had not been receiving any services.Interview and clinical record review with the Director of Rehabilitation on 3/23/26 at 8:54 AM identified on 1/16/26 a screen was requested for an evaluation and Resident #107 was subsequently seen for three sessions. However, Resident #107 still required the use of a cervical collar which he/she refused so services were not provided due to safety. Resident #107 subsequently received medical clearance 2/20/26 to discontinue the use of the collar but did not resume services with the facility as Resident #107 requested outpatient services in the community. The Director of Rehabilitation further identified Resident #107's status was discussed in morning report and nursing was responsible for any follow-up consultation, recommendations and related scheduling.Interview and clinical documentation review with the Unit Secretary on 3/23/26 at 9:37 AM identified she was responsible for the scheduling of outside appointments for the residents. Unit Secretary #1 indicated information regarding appointments was provided to her by nursing staff through messaging in the electronic medical record. The Unit Secretary further identified she was first notified of a referral for rehabilitation services on 3/5/26, spoke to Resident #107 who confirmed his/her desire to receive outpatient rehabilitation and scheduled the first appointment for 3/13/26.Interview and clinical record review with APRN #2 on 3/24/26 at 10:12 AM identified Resident #107 had recommendations for continued therapy following an orthopedic consultation on 1/5/26 and was transitioning to outside rehabilitation services. APRN #2 was aware Resident #107 was not compliant at times about wearing the cervical collar but otherwise was not notified rehabilitative services had not started from 1/5/26 and thought Resident #107 was making strides in therapy as she observed him/her ambulating in the hall with a walker. Had she been aware, she would have referred Resident #107 back to the orthopedic provider as soon as possible for clearance. APRN #2 further identified Resident #107 also had other co-occurring medical issues at the time but was unable to find any orders to hold discontinue services at any time or any documented concerns related to refusals.An interview with the DNS on 3/25/26 at 11:05 AM identified the physician should have been notified that rehabilitative services were not being provided for Resident #107.A review of the facility policy for change of condition notification directed that the facility will notify the resident, residents health care provider and legal representative when there is a change in condition and document findings in the clinical record.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, and interviews for 2 of 7 nurse aide (NA #4 and #5) personnel files reviewed, the facility failed to ensure criminal background checks were completed, per the facility's screening prospective employee's policy. The findings include: a. NA #4 was hired on [DATE]. Review of NA #4's personnel file identified an undated Applicant Background Check Management System (ABCMS) Person Summary that identified NA #4's current eligibility determination was in process, and the ABCMS Final Registry Results Form dated [DATE] identified NA #4 had not been previously determined eligible for employment and must be fingerprinted. b. NA#5 was hired on [DATE].Review of NA #5's personnel file identified an undated Applicant Background Check Management System (ABCMS) Person Summary that identified NA #5's current eligibility determination noted: a new application must be submitted, and the ABCMS Final Registry Results Form dated [DATE] identified NA #4 had not been previously determined eligible for employment and must be fingerprinted. Interview with the HR Director on [DATE] at 10:10 AM indicated that on [DATE], subsequent to NA #4's personnel file being requested for review by the survey team, she identified that NA #4 had not completed the finger printing portion of the criminal background check and had not been determined eligible for employment. The HR Director indicated that NA #4 not being fingerprinted, prior to beginning her employment at the facility, was an oversight. The HR Director indicated as soon as the issue was identified, NA #4 was notified that her background check was incomplete and she was sent for fingerprinting, and would be removed from the schedule until she was determined eligible for employment. Interview with the HR Director on [DATE] at 1:00 PM indicated that, subsequent to NA #5's personnel file being requested for review by the survey team, it was identified that her ABCMS Person Summary determination directed for a new application to be submitted. The HR Director indicated that determination would be a result of 1 of 2 reasons, NA #5 never completed the fingerprinting portion of the back ground check or was greater than 3 years and had expired. The HR Director identified that she began working at the facility on [DATE] and both NA #4 and NA #5 had been hired during her time as the HR Director. In November/December of 2025 she began working with corporate on a new process for managing the fingerprinting portion of prospective employee's background checks to ensure employees did not begin orientation until the full background check, including fingerprinting, had been completed, as was identified that some employees had begun orientation prior to completing their fingerprinting. The HR Director identified that NA #5 would be removed from the schedule until her fingerprinting was completed and she was determined eligible for employment, and an audit of all personnel files to determine ABCMS eligibility would be initiated immediately. Interview with the Administrator on [DATE] at 12:06 PM identified that he would expect all state and federal guidelines to be followed, regarding screening prospective employees. The Administrator further indicated that there was a process change with the HR Director, a while ago, to ensure new employees did not begin work until they were determined eligible by ABCMS. An ABCMS Person Summary, provided on [DATE], identified NA #4's current eligibility determination was eligible. The Employment Policy directs all prospective employees must accurately complete an employment application form and arrange for a personal interview. All employment offers are subject to the receipt of satisfactory references, CNA registry, OIG, and criminal background checks. Falsification, misrepresentation, or omission of any facts on the employment application form or during the pre-employment interview may be grounds for dismissal.

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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 review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #22) reviewed for abuse, the facility failed to report an allegation of abuse to the state agency. The findings include:a. Resident #22 was admitted in October 2024 with diagnoses that included anoxic brain damage and dementia.The quarterly MDS dated [DATE] identified Resident #22 had severely impaired cognition and required one person assist with locomotion with the use of a manual wheelchair.The care plan dated 1/22/25 identified Resident #22 had a behavior problem that included anxiety and aggression towards others. Interventions included monitoring behavior and administering medications as ordered.b. Resident #129 was admitted in August 2023 with diagnoses that included schizophrenia and dementia.The quarterly MDS dated [DATE] identified Resident #129 had moderately impaired cognition and was independent with ambulation.The care plan dated 1/7/25 identified Resident #129 had a mood problem related to schizophrenia and a history of elopement with wandering behaviors. Interventions include monitoring and reporting changes in mood patterns and offer diversional activities if wandering.A Medical APRN progress note (Resident #129) dated 9/26/26 at 8:30 AM identified nursing reported Resident #129 with a history of inappropriate behaviors with indefinite 1:1 supervision who recently had an incident where he/she inappropriately touched another residents body part (Resident #22). The nursing director is requesting further medical workup. Resident #129 was unable to provide information or cooperate with instructions/boundaries regarding information or appropriate behaviors. Resident #129 was to be redirected as needed and continue 1:1 monitoring.A Psychiatric APRN progress note (Resident #129) dated 9/26/25 at 6:40 PM identified Resident #129 was evaluated for displaying sexually inappropriate behaviors per nursing. Resident #129 has a history of sexually inappropriate behaviors (towards Resident #22) and under 1:1 staff supervision. Resident #129 was calm with no anxiety, denied any sexually inappropriate behaviors and was not a risk to self or others.For Resident #22, a review of the clinical record identified no documentation regarding the incident and no completed reportable event form.Interview with the DNS on 3/24/26 at 1:53 PM identified she was unaware of the alleged incident and would have to further investigate the matter. Subsequently, the incident was reported.Interview with APRN #1 on 3/24/26 at 3:21 PM identified while reviewing the unit communication book on 9/26/25 she became aware of an incident involving Resident #129 who again, exhibited sexually inappropriate behaviors towards the same resident as he/she previously had in the past. APRN #1 indicated she was informed by (unidentified) nursing staff that prior to 9/26/25, Resident #22 had been sexually inappropriately touched by Resident #129 while under 1:1 staff supervision. APRN #1 indicated the incident involved Resident #129 grabbing Resident #22's left chest while passing in the hall and did not want to let go until 1:1 staff intervened and separated the two residents. APRN #1 spoke briefly to Resident #22 who reported while the breast was not touched, Resident #129 grabbed his/her chest causing him/her to feel uncomfortable. APRN #1 further identified Resident #129 was unusually confused during that time and received a medical workup to rule out potential underlying causes. Subsequent interview with the DNS on 3/24/26 at 3:34 PM identified she was aware of the alleged incident, but it was reported Resident #129 grabbed Resident #22's shirt, not the breast and was not threatening, therefore determined no further follow up was necessary. Resident #129 subsequently received a medical workup and 1:1 supervision continued as ordered.Interview with NA #10 on 3/24/26 at 3:59 PM identified she was the assigned 1:1 staff during 3:00 PM to 11:00 PM on 9/25/26 and overnight 11:00 PM to 7:00 AM shift until 9/26/26. NA #10 indicated between 4:00 PM and 5:00 PM, she was walking down the hall with Resident #129. Resident #22 was approaching from the opposite direction. As they passed, with NA #10 positioned between them, Resident #129 reached out and grabbed Resident #22's shirt just above the breast holding it for approximately three seconds before NA #10 was able to (continued on next page)

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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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	separate the two. NA #10 indicated that although it did not appear Resident #129 was obviously aggressive or threatening, it was difficult to determine his/her state of mind or intent at the time of the incident. However, it was known Resident #129 had a prior history of sexual inappropriateness with Resident #22. NA #10 further identified there had been other occasions where Resident #129 had grabbed Resident #22's shirt in the past but the behavior was redirected and reported to nursing.Review of the Abuse policy directs that the facility notify the Department of Public Health Immediately but no later than two hours after an allegation is made if the events that cause the allegation involve abuse or results in serious bodily harm, but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Law enforcement will be notified in a reasonable time frame.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #22) reviewed for abuse, the facility failed to investigate an allegation of abuse and protect the resident during the investigation. The findings include:a. Resident #22 was admitted in October 2024 with diagnoses that included anoxic brain damage and dementia.The quarterly MDS dated [DATE] identified Resident #22 had severely impaired cognition and required one person assist with locomotion with the use of a manual wheelchair.The care plan dated 1/22/25 identified Resident #22 had a behavior problem that included anxiety and aggression towards others. Interventions included monitoring behavior and administering medications as ordered.b. Resident #129 was admitted in August 2023 with diagnoses that included schizophrenia and dementia.The quarterly MDS dated [DATE] identified Resident #129 had moderately impaired cognition and was independent with ambulation.The care plan dated 1/7/25 identified Resident #129 had a mood problem related to schizophrenia and a history of elopement with wandering behaviors. Interventions include monitoring and reporting changes in mood patterns and offer diversional activities if wandering.A Medical APRN progress note (Resident #129) dated 9/26/26 at 8:30 AM identified nursing reported Resident #129 with a history of inappropriate behaviors with indefinite 1:1 supervision who recently had an incident where he/she inappropriately touched another residents body part (Resident #22). The nursing director is requesting further medical workup. Resident #129 was unable to provide information or cooperate with instructions/boundaries regarding information or appropriate behaviors. Resident #129 was to be redirected as needed and continue 1:1 monitoring.A Psychiatric APRN progress note (Resident #129) dated 9/26/25 at 6:40 PM identified Resident #129 was evaluated for displaying sexually inappropriate behaviors per nursing. Resident #129 has a history of sexually inappropriate behaviors (towards Resident #22) and under 1:1 staff supervision. Resident #129 was calm with no anxiety, denied any sexually inappropriate behaviors and was not a risk to self or others.For Resident #22, a review of the clinical record identified no documentation regarding the incident and no completed reportable event form and/or investigation.Interview with the DNS on 3/24/26 at 1:53 PM identified she was unaware of the alleged incident and would have to further investigate the matter. Subsequently, the incident was reported.Interview with APRN #1 on 3/24/26 at 3:21 PM identified while reviewing the unit communication book on 9/26/25 she became aware of an incident involving Resident #129 who again, exhibited sexually inappropriate behaviors towards the same resident as he/she previously had in the past. APRN #1 indicated she was informed by (unidentified) nursing staff that prior to 9/26/25, Resident #22 had been sexually inappropriately touched by Resident #129 while under 1:1 staff supervision. APRN #1 indicated the incident involved Resident #129 grabbing Resident #22's left chest while passing in the hall and did not want to let go until 1:1 staff intervened and separated the two residents. APRN #1 spoke briefly to Resident #22 who reported while the breast was not touched, Resident #129 grabbed his/her chest causing him/her to feel uncomfortable. APRN #1 further identified Resident #129 was unusually confused during that time and received a medical workup to rule out potential underlying causes. Subsequent interview with the DNS on 3/24/26 at 3:34 PM identified she was aware of the alleged incident, but it was reported Resident #129 grabbed Resident #22's shirt, not the breast and was not threatening, therefore determined no further follow up was necessary. Resident #129 subsequently received a medical workup and 1:1 supervision continued as ordered. The DNS further identified the facility was aware of the potential of future physical contact between Resident #129 and Resident #22, however, Resident #22's responsible party was not in agreement with moving him/her to another unit and Resident #129 required a secure unit due to a history of attempted elopement from another facility, although no documentation was provided. Interview with NA #10 on 3/24/26 at 3:59 PM identified she was the assigned 1:1 staff during 3:00 PM to 11:00 PM on 9/25/26 and overnight 11:00 PM to 7:00 AM shift until 9/26/26. NA #10 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated between 4:00 PM and 5:00 PM, she was walking down the hall with Resident #129. Resident #22 was approaching from the opposite direction. As they passed, with NA #10 positioned between them, Resident #129 reached out and grabbed Resident #22's shirt just above the breast holding it for approximately three seconds before NA #10 was able to separate the two. NA #10 indicated that although it did not appear Resident #129 was obviously aggressive or threatening, it was difficult to determine his/her state of mind or intent at the time of the incident. However, it was known Resident #129 had a prior history of sexual inappropriateness with Resident #22. NA #10 further identified there had been other occasions where Resident #129 had grabbed Resident #22's shirt in the past but the behavior was redirected and reported to nursing.Review of the Abuse policy directs following any allegation, administrative nursing staff or nursing supervisor/charge nurse assumes responsibility for immediate notification of the Administrator/DNS by phone, notification of appropriate department head, physician to conduct a physical/mental assessment, initiate an immediate investigation of the alleged incident, interview resident/other resident witnesses with each interview dated, documented and signed by the supervisor designee, interview staff witnesses or other available witnesses. Witnesses are to document statements that are dated and signed. The facility investigation is to be completed within 5 days of the incident with findings completed in writing and reviewed by the QAA committee.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #22) reviewed for abuse, the facility failed to revise the care plan to address and prevent further occurrences of non-consensual physical/sexual contact by Resident #129. The findings include:a. Resident #22 was admitted in October 2024 with diagnoses that included anoxic brain damage and dementia.The quarterly MDS dated [DATE] identified Resident #22 had severely impaired cognition and required one person assist with locomotion with the use of a manual wheelchair.The care plan dated 1/22/25 identified Resident #22 had a behavior problem that included anxiety and aggression towards others. Interventions included monitoring behavior and administering medications as ordered.b. Resident #129 was admitted in August 2023 with diagnoses that included schizophrenia and dementia.The quarterly MDS dated [DATE] identified Resident #129 had moderately impaired cognition and was independent with ambulation.The care plan dated 1/7/25 identified Resident #129 had a mood problem related to schizophrenia and a history of elopement with wandering behaviors. Interventions include monitoring and reporting changes in mood patterns and offer diversional activities if wandering.A Medical APRN progress note (Resident #129) dated 9/26/26 at 8:30 AM identified nursing reported Resident #129 with a history of inappropriate behaviors with indefinite 1:1 supervision who recently had an incident where he/she inappropriately touched another residents body part (Resident #22). The nursing director is requesting further medical workup. Resident #129 was unable to provide information or cooperate with instructions/boundaries regarding information or appropriate behaviors. Resident #129 was to be redirected as needed and continue 1:1 monitoring.A Psychiatric APRN progress note (Resident #129) dated 9/26/25 at 6:40 PM identified Resident #129 was evaluated for displaying sexually inappropriate behaviors per nursing. Resident #129 has a history of sexually inappropriate behaviors (towards Resident #22) and under 1:1 staff supervision. Resident #129 was calm with no anxiety, denied any sexually inappropriate behaviors and was not a risk to self or others.For Resident #22, review of the care plan identified it was not revised to include interventions to reduce future risk of physical/sexual contact and Resident #129 and Resident #22 remained on the same unit.Interview with the DNS on 3/24/26 at 1:53 PM identified she was unaware of the alleged incident and would have to further investigate the matter. Subsequently, the incident was reported.Interview with APRN #1 on 3/24/26 at 3:21 PM identified while reviewing the unit communication book on 9/26/25 she became aware of an incident involving Resident #129 who again, exhibited sexually inappropriate behaviors towards the same resident as he/she previously had in the past. APRN #1 indicated she was informed by (unidentified) nursing staff that prior to 9/26/25, Resident #22 had been sexually inappropriately touched by Resident #129 while under 1:1 staff supervision. APRN #1 indicated the incident involved Resident #129 grabbing Resident #22's left chest while passing in the hall and did not want to let go until 1:1 staff intervened and separated the two residents. APRN #1 spoke briefly to Resident #22 who reported while the breast was not touched, Resident #129 grabbed his/her chest causing him/her to feel uncomfortable. APRN #1 further identified Resident #129 was unusually confused during that time and received a medical workup to rule out potential underlying causes. Subsequent interview with the DNS on 3/24/26 at 3:34 PM identified she was aware of the alleged incident, but it was reported Resident #129 grabbed Resident #22's shirt, not the breast and was not threatening, therefore determined no further follow up was necessary. Resident #129 subsequently received a medical workup and 1:1 supervision continued as ordered. The DNS further identified the facility was aware of the potential of future physical contact between Resident #129 and Resident #22, however, Resident #22's responsible party was not in agreement with moving him/her to another unit and Resident #129 required a secure unit due to a history of attempted elopement from another facility, although no documentation was provided. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #10 on 3/24/26 at 3:59 PM identified she was the assigned 1:1 staff during 3:00 PM to 11:00 PM on 9/25/26 and overnight 11:00 PM to 7:00 AM shift until 9/26/26. NA #10 indicated between 4:00 PM and 5:00 PM, she was walking down the hall with Resident #129. Resident #22 was approaching from the opposite direction. As they passed, with NA #10 positioned between them, Resident #129 reached out and grabbed Resident #22's shirt just above the breast holding it for approximately three seconds before NA #10 was able to separate the two. NA #10 indicated that although it did not appear Resident #129 was obviously aggressive or threatening, it was difficult to determine his/her state of mind or intent at the time of the incident. However, it was known Resident #129 had a prior history of sexual inappropriateness with Resident #22. NA #10 further identified there had been other occasions where Resident #129 had grabbed Resident #22's shirt in the past but the behavior was redirected and reported to nursing.A review of the facility policy for Comprehensive Person-Centered Care Plan directed that the interdisciplinary team address resident strengths, needs and problems identified and develop a comprehensive care plan to properly care for the residents and will address preferences, goals, desired outcomes and plan for discharge. The care plan will be kept current on an ongoing basis, and disciplines will be responsible for updating the care plan when there is a new problem that requires a discipline to intervene.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 administer transdermal medication according to professional standards during a 2 week period when licensed staff applied a 12.5 mcg Fentanyl patch every 3 days despite the order directing 75 mcg be applied. 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 and 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. A written statement by LPN #10 dated 3/3/26 at 3:15 PM (who worked 2/16/26) identified she applied a 12 mcg Fentanyl patch 12 mcg but did not review the physician's order in its entirety. The physician's order at that time directed Fentanyl 75 mcg patch.A written statement by LPN #12 (agency nurse) dated 3/3/26 at 3:00 PM identified that she worked on 2/22/26, she administered Resident #125's Fentanyl 12 mcg Patch. LPN #12 indicated she did not recognize that the physician's order in the e-MAR reflected a different dosage and acknowledged she did not fully adhere to the five rights of medication administration. LPN #12 indicated Resident #125 had received a Fentanyl 12 mcg Patch. LPN #12 indicated she has since reviewed her medication verification process to ensure full adherence to the five rights of medication administration.A written statement by LPN #12 (agency nurse) dated 3/3/26 at 3:00 PM identified that she worked on 2/25/26, she administered Resident #125's Fentanyl 12 mcg patch. LPN #12 indicated she did not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recognize that the physician's order in the e-MAR reflected a different dosage and acknowledged she did not fully adhere to the five rights of medication administration. LPN #12 indicated Resident #125 had received a Fentanyl 12 mcg Patch. LPN #12 indicated she has since reinforced her medication verification process to ensure full adherence to the five rights of medication administration and prevent future errors.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 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.A written statement by LPN #9 (agency nurse) dated 3/4/26 at 7:31 PM identified that on the day that she worked (2/19/26), LPN #9 indicated she applied a Fentanyl patch to Resident #125 as ordered. LPN #9 indicated she was unable to recall the exact dosage that was applied. LPN #9 indicated that the previously existing Fentanyl patch was removed and destroyed with a staff witness in accordance with facility policy. The summary 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 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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; 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 (continued on next page)

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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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #103) reviewed for accidents, the facility failed to ensure a safe transfer of the resident with a mechanical lift per the physician's order. The findings include:Resident #103 was admitted to the facility in May 2020 with diagnoses that included Alzheimer's disease, colostomy and muscle weakness.A physician's order dated 6/26/23 directed to transfer the resident with the assistance of 2 staff using a mechanical lift.The quarterly MDS dated [DATE] identified Resident #103 had severely impaired cognition, had an ostomy, was always incontinent of bladder and was dependent on staff to assist with toileting, bathing, and transfers.The care plan dated 2/28/25 identified Resident #103 had a self-care deficit due to dementia. Interventions included to provide assistance of 2 staff using a mechanical lift.A nurse aide care card dated 5/11/25 identified Resident #103 required an assist x 2 using a mechanical lift for transfers at wheelchair level.Review of a Reportable Event Form dated 5/11/25 at 7:30 PM identified Resident #103 had a witnessed fall while being transferred in a mechanical lift. Review of the report included a written statement from NA #3 (agency nurse aide), who identified she was transferring the resident alone at the time of the fall. NA #3 indicated she did not realize the mechanical lift pad was not under the resident properly and during the transfer with the mechanical lift, Resident #103 slid out of the pad. A change of condition nursing assessment note dated 5/11/25 at 9:48 PM identified Resident #103 slipped out of the mechanical lift sling while NA #3 was attempting to transfer the resident on her own. The note identified that Resident #103 was unable to relay what occurred. The note further identified Resident #103's neuros were within normal limits, he/she was able to move all extremities without difficulty and no signs/symptoms of pain or discomfort were noted. The note also identified that Resident #103 was assisted back to bed with use of the mechanical lift without difficulty.Interview with NA #3 on 3/23/26 at 11:25 AM identified that she was the nurse aide assigned to Resident #103 on 5/11/25 when the fall occurred. NA #3 identified she was preparing Resident #103 for bed, and that she was attempting to transfer Resident #103 from the wheelchair to the bed using a mechanical lift by herself. NA #3 identified that during the transfer she identified the pad was not situated under Resident #103 properly and that Resident #103 began to slip out of the lift and ultimately fell. NA #3 identified that Resident #103 did not fall far but did hit his/her bottom on the floor. NA #3 identified that she attempted to catch Resident #103 prior to the fall but was not able to in time. NA #3 identified she attempted the transfer by herself because she had attempted to try and find another staff member to help her but was unable find someone. NA #3 identified she did not review the nurse aide care card and relied on information that she received in report, however she was aware, due to the need for a mechanical lift, that Resident #103 would require 2 staff members for the transfer. NA #3 identified there was no urgency to transfer Resident #103, but that she had other residents to attend to and wanted to finish care with Resident #103. NA #3 failed to identify why she was not able to wait until another staff member was available to assist with Resident #103's transfer instead of attempting it on her own. NA #3 identified that she called for help following the fall and stayed with Resident #103 when a nurse arrived. NA #3 identified that following incident, she was sent home and did not return to the facility. Interview with the Nurse Scheduler on 3/23/26 at 12:30 PM identified NA #3 was an agency nurse aide who worked at the facility for 2 shifts on 5/10/25 - 5/11/25. The Nurse Scheduler identified that NA #3 did not work a full shift on 5/11/25 and was sent home following the incident with Resident #103, and that the facility placed her on ?do not return' status at the facility. Interview with the DNS on 3/25/26 at 12:45 PM identified that Resident #103 was always to be transferred with 2 staff members and a mechanical lift in and out of bed, and that immediately following the fall on 5/11/25, NA #3 was sent home, and the staffing agency was notified she was not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to return to the facility. The DNS further identified that all nursing staff also were in serviced following the incident that any resident who required a mechanical lift were always to have 2 staff present. Although requested, a policy on use of a mechanical lift was not provided.The facility policy on safe patient/resident handling and movement directed it was the duty of employees to take reasonable care of their own health and safety as well as that of their residents during handling activities by following the policy. Noncompliance would indicate a need for retraining/discipline. The policy also directed that staff were to avoid hazardous patient handling and movement tasks whenever possible. The policy further directed that use of mechanical lifting devices or other approved patient handling aids should be used with instructions and training.

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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 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. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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; 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 Fentanyl 75 mcg patch; however, they were administering Fentanyl 12 mcg patches on Resident #125. RN #8 indicated that (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #107) reviewed for rehabilitation, the facility failed to implement specialty service recommendations in a timely manner for a resident requiring rehabilitative services. The findings include:Resident #107 was admitted in November 2025 with diagnoses that included nondisplaced fracture of the seventh cervical vertebra, and non-displaced fracture of the right tibia (leg bone) secondary to a motor vehicle accident.The admission MDS dated [DATE] identified Resident #107 was cognitively intact, required two person assist with bed mobility, transfers, utilized a manual wheelchair with one assist for locomotion and was receiving occupational, physical and speech therapy.The care plan dated 11/21/25 identified Resident #107 had a fracture of the right tibia and cervical spine. Interventions included maintaining a cervical collar (neck collar) at all times, follow up with orthopedic consultations as indicated and provide occupational and physical therapy evaluation according to physician orders.Physical and Occupational Therapy Discharge Summaries dated 12/24/25 identified Resident #107 was independent bed mobility, sitting, standing and toileting with supervision/touch assist and refusing ambulation at the time. Resident #107 reached the highest functional level with continued level of function considered ?good' with consistent staff follow-through.Orthopedic consult (related to tibial fracture) dated 1/5/26 identified Resident #107 was evaluated for a tibial fracture and left hip dislocation. Recommendations included progressing to protected weight bearing status as tolerated, bilateral hip, knee and ankle range of motion (ROM) as tolerated with focus to the right knee ROM three times daily with aim of 0-90 degrees in the coming two weeks (2/9/26).APRN progress note dated 1/5/26 identified Resident #107 returned from orthopedics with a referral for ambulatory referral to rehabilitation services which have been reviewed and placed for scheduling. Referral indicates weight-bearing as tolerated to bilateral lower extremities, range of motion exercises bilateral hips, knees, ankles as tolerated, swelling and edema management, gait and balance exercises, and general body exercises requesting three days a week of physical therapy. Staff were to notify the provider of outpatient orthopedic consult results and any new orders for review.Physician orders dated 1/16/26, 11 days after orthopedic recommendations, directed PT 3-5 days/week for 8 weeks.Physical Therapy evaluation dated 1/16/26 identified the continued need for services for strengthening, balance and toileting until 3/12/26.Physical Therapy Discharge summary dated [DATE] identified Resident #107 was deemed not safe to continue treatment due to non-compliance in wearing the cervical collar. Resident #107 was to continue mobility at wheelchair level until follow up appointment in 2/2026 regarding any continued need for the cervical collar.Occupational Therapy Evaluation dated 1/23/26 identified therapy services were limited to evaluation only and were not continued due to non-compliance in the use of a cervical collar. Resident #107 was to follow up with orthopedics (for the continued use of the cervical collar) in 2/2026.Nurse's note dated 1/27/26 at 3:09 PM identified per orthopedics (for the cervical collar), Resident #107 was to continue to wear the cervical collar until his/her follow up appointment in 2/2026.APRN progress note dated 1/29/26 at 9:30 AM identified Resident #107 was cleared by orthopedics for weight bearing and was making excellent progress with physical therapy. The plan included continued OT/PT with weight bearing as cleared by orthopedics.Outpatient Rehabilitation consult dated 2/9/26 recommended OT and PT three times weekly for weight bearing, ROM and strengthening for the bilateral lower extremities.APRN progress note dated 2/10/26 at 11:31 AM identified ongoing rehabilitation after a right tibial plateau fracture. Resident #107 returned with ambulatory referral paperwork for outpatient rehabilitation services from orthopedics (for tibial fractur). Referral order reviewed and placed for scheduling today.APRN progress notes dated 2/11/26 through 2/19/26 identified Resident #107 was continuing to make progress in physical therapy and awaiting outpatient physical therapy.Orthopedic consult (for the cervical collar) dated 2/20/26 (continued on next page)

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

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommended Resident #107's cervical collar to be discontinued.APRN progress notes dated 2/20/26 through 3/3/26 identified Resident #107 was continuing to make progress in physical therapy and awaiting outpatient physical therapy.Review of nursing progress notes dated 1/6/26 through 3/3/26 did not include documentation related to Resident #107 not receiving rehabilitation services.Neurology consult dated 3/4/26, 12 days post cervical collar discontinuation, identified Resident #107 needed rehabilitation therapy three times weekly for weight bearing and strengthening according to orthopedic recommendations.Interdisciplinary ?Secure Conversations' progress note dated 3/4/26 identified #107 was recommended physical therapy three times weekly following an orthopedic consult for weight bearing, ROM and strengthening for the bilateral lower extremities.Interdisciplinary ?Secure Conversations' progress note dated 3/5/26 identified #107 requested the physical therapy referral be sent to a community outpatient rehabilitation service and the referral was faxed.Resident #107 received the first evaluation for treatment on 3/13/26, twenty days post removal of the cervical collar.Interview with Resident #107 on 3/22/26 at 7:50 AM identified he/she was expected to begin outpatient physical therapy beginning sometime in January but was not seen until 3/13/26. Resident #107 indicated during a neurology consult on 3/4/26, providers inquired about rehabilitation services and were surprised to learn he/she had not been receiving any services.Interview and clinical record review with the Director of Rehabilitation on 3/23/26 at 8:54 AM identified Resident #107 was provided OT, PT and speech services from 11/3/25 to 12/24/25 for strengthening and cognition. Resident #107 was subsequently discharged after meeting his/her goals given orthopedic restrictions during that time. On 1/16/26 a screen was requested for an evaluation and Resident #107 was subsequently seen for three sessions. However, Resident #107 still required the use of a cervical collar which he/she refused so services were not provided due to safety. Resident #107 subsequently received medical clearance 2/20/26 to discontinue the use of the collar but did not resume services with the facility as Resident #107 requested outpatient services in the community. The Director of Rehabilitation further identified Resident #107's status was discussed during morning report and nursing was responsible for any follow-up consultation, recommendations and related scheduling.Interview with RN #6 on 3/23/26 at 9:17 AM identified she was the assigned unit manager for the floor where Resident #107 resided. RN #6 indicated the charge nurse; nursing supervisor and herself share the responsibility for reviewing and referring specialty consultation recommendations to the APRN and responding appropriately. Consult recommendations were addressed depending on who received the information first and RN #6 was not responsible for ensuring the completeness of the task by another nurse. RN #6 further identified she was not aware of any lapse in implementing rehabilitation services for Resident #107 adding the unit secretary was responsible for the scheduling of outside appointments.Interview with the Unit Secretary on 3/23/26 at 9:37 AM identified she was responsible for the scheduling of outside appointments for the residents. Unit Secretary #1 indicated information regarding appointments was provided to her by nursing staff through messaging in the electronic medical record. The Unit Secretary further identified she was first notified of a referral for rehabilitation services on 3/5/26, spoke to Resident #107 who confirmed his/her desire to receive outpatient rehabilitation and scheduled the first appointment for 3/13/26.Interview and clinical record review with the DNS on 3/24/2026 at 7:32 AM identified the charge nurses, unit manager and nursing supervisor were responsible for reviewing specialty consultations, referring to the APRN and any address any required follow up. The DNS indicated Resident#107 had recommendations from orthopedics, however the facility rehabilitation staff were unable to provide services safely due to his/her noncompliance with wearing the cervical collar. The DNS was unable to explain the lapse in implementing rehabilitation services between the time of the orthopedic consult dated 1/5/26 until 1/16/26 when an evaluation took place and again from 2/20/26 when the cervical collar was discontinued until the time rehabilitation services began on 3/13/26 but indicated refusals or issues related to scheduling would have been documented. The DNS further identified Resident #107 should have been referred to physical therapy as soon as possible once the collar was discontinued and in (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accordance with his/her preference.Subsequent interview with RN #6 on 3/24/26 at 9:08 AM identified he contacted orthopedics at Resident #107's request to determine if he/she was still required to wear the cervical collar but was unaware of any issues related to non-compliance with its use. RN #6 further identified she did not follow up with the outpatient physical therapy referral once the cervical collar was discontinued again noting the Unit Secretary was responsible for scheduling outside appointments.Interview and clinical record review with APRN #2 on 3/24/26 at 10:12 AM identified Resident #107 had recommendations for continued therapy following an orthopedic consultation on 1/5/26 and was transitioning to outside rehabilitation services. APRN #2 was aware Resident #107 was non complaint at times about wearing the cervical collar but otherwise, was not aware rehabilitative services had not started from 1/5/26 at and thought Resident #107 was making strides in therapy as she observed him/her ambulating in the hall with a walker. Had she been aware, she would have referred Resident #107 back to the orthopedic provider as soon as possible for clearance. APRN #2 further identified Resident also had other co-occurring medical issues at the time but was unable to find any orders to hold discontinue services at any time or any documented concerns related to refusals.Although requested, a policy for responding to special service recommendations was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #10) reviewed for respiratory care, the facility failed maintain infection control standards for a resident requiring specialized airway care. The findings include:Resident #10 was admitted to the facility in January 2020 with diagnoses that included traumatic subarachnoid hemorrhage with loss of consciousness and persistent vegetative state. The quarterly MDS dated [DATE] identified Resident #10 had severely impaired cognition, required two person assist with bed mobility, transfers and had a tracheostomy (opening in the neck to facilitate breathing). The care plan dated 2/19/26 identified Resident #10 had an ADL deficit with limitations in mobility and altered respiratory status related to the presence of a tracheostomy. Interventions included one to two staff for ADL care, deep suction as needed and administer medication according to physician orders. Physician orders dated 3/4/26 directed to change the inner cannula Shiley #6.5mm every shift for tracheostomy care and suction with a #10 French suction catheter every shift and as needed.Observation on 3/24/26 at 11:06 AM identified LPN #6 washed her hands, put on clean gloves and removed the tracheostomy inner cannula using her right hand and discarded it in garbage at the bedside. LPN #6 then removed her gloves and proceeded to open the sterile tracheostomy care kit without first performing hand hygiene. LPN #6 preceded to place the pop-up basin to the side of the bedside table using the same right hand, don sterile gloves and set up a sterile drape on the bedside table. LPN #6 continued with the task of removing soiled bandages and cleansing around the tracheostomy using the left hand. Using the same right hand when removing the inner cannula, LPN #6 opened the sterile inner cannula, held on to the end with the opening and attempted to advance the inner cannula. The task was interrupted.Interview with LPN #6 on 3/24/26 at 11:06 AM identified she thought she maintained sterile technique during the procedure.Interview with RN #5, Regional Nurse Consultant on 3/25/2026at 1:38 PM identified that while sterile technique was not required for the procedure, LPN #6 should have performed hand hygiene after the removal of the inner cannula and before opening the sterile kit and donning sterile gloves.A review of the facility policy for Tracheostomy Care directed Tracheostomy care to be completed when an inner cannula is changed or cleaned. The procedure directs to wash hands once the inner cannula is removed from the trach tube and apply clean gloves before proceeding.