STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075381	A. Building B. Wing	07/03/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observation, review of facility documentation, job descriptions, and interviews for 5 of 5 units, the facility failed to ensure the environment was clean, sanitary, maintained in good repair and homelike. The findings included: Review of the maintenance repair log dated 4/2/24 through 6/28/24 failed to reflect documentation regarding the condition of resident rooms. Review of the environmental rounds worksheet for infection prevention dated 6/26/24 and the random environmental rounds form dated 6/27/24 identified rounds were completed by RN #1. The environmental rounds worksheet for infection prevention and the random environmental rounds form failed to reflect documentation of the condition of resident rooms. Observations on 7/2/24 at 1:20 PM through 2:40 PM, and on 7/2/24 at 2:45 PM through 3:00 PM with the Director of Maintenance, and the ADNS identified the following: a. Damaged, missing and/or broken floor tiles in the bedroom on the 3rd floor, A Wing, in room [ROOM NUMBER], and on the 3rd floor, B Wing, in rooms 317, 329, and both elevators. b. Damaged, yellow stained floor tiles in the bathroom on the 3rd floor, A Wing, in rooms 303, 305, and on the 3rd floor, B Wing, in rooms 330, and 331. c. Damaged, stains, chipped and/or marred bedroom walls, and/or bedroom wallpaper, and bathroom walls, on the 2nd floor, A Wing, in rooms [ROOM NUMBER]. On the 2nd floor, B Wing, in rooms 215, 221, 222, 223, Resident Lounge, and 226. On the 3rd floor, A Wing, in rooms 301, 303, 304, 305, 306, 307, 308, hallway, and 310. On the 3rd floor, B Wing, in rooms 314, 316, 318, 319, 320, 321, 322, 324, 330, 331, and the Shower Room. On the 4th floor in rooms 414, 417, 418, 421, hallway, 425, Recreation Area on the 4th floor. d. Damaged, dirty and/or missing cove base in bedroom and bathroom on the 3rd floor, A Wing, in rooms 303, and on the 3rd floor, B Wing, in rooms [ROOM NUMBER]. e. Stains, dirt, debris, discoloration and/or wax build up on the floor bedrooms on the 3rd floor, A Wing, in rooms 306, 307, 310, 311, 312, and 313. On the 3rd floor, B Wing, in rooms 314, 315, 316, 318, 319, 320, 323, 324, 328, and 330. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Stains, dirt, debris, discoloration and/or wax build up on the floor in the bathroom on the 3rd floor A Wing, in room [ROOM NUMBER]. On the 3rd floor, B Wing, in rooms 314, 317, 321, 323, and 324. g. Damaged, peeling, and/or brown stains on bedroom and bathroom ceiling, on the 2nd floor, A Wing, in rooms [ROOM NUMBER]. On the 3rd floor A Wing in rooms 301. On the 4th floor in the Recreation Area. h. Damaged, rusty, and/or stain air conditioner on the 4th floor in room [ROOM NUMBER]. i. Damaged, torn, and/or stained carpet on the 2nd floor hallway. The 3rd floor, A/B Wing hallway in the corridor at the elevator area. On the 3rd floor B Wing hallway. On the 4th floor Recreation Area, and the 4th floor corridor at the elevator area. j. Damaged, peeling, and/or stained bed footboard in bedroom on the 3rd floor, A Wing, in rooms 310, and 312. On the 3rd floor, B Wing, in room [ROOM NUMBER]. k. Damaged, off-track, and/or stains privacy curtain in bedroom on the 3rd floor, A Wing, in rooms 301, and 304. On the 3rd floor, B Wing, in rooms 321, and 329. l. Damaged, torn, and/or broken bathroom cabinet in room on the 3rd floor, A Wing, 303, and on the 3rd floor, B Wing, in room [ROOM NUMBER]. m. Damaged, broken, peeling, and/or missing dresser, and/or nightstand drawer knob in bedroom on 3rd floor on the B Wing in rooms 315 (2nd drawer handle off), and 320 (2nd drawer damaged). n. Damaged and/or marred door frame, door in bedroom and/or bathroom on the 3rd floor in rooms 317, and 321. Interview with the Director of Maintenance on 7/2/24 at 3:00 PM identified he has been employed by the facility since November 2023. The Director of Maintenance indicated he was aware of some of the issues. The Director of Maintenance indicated he and the maintenance staff are trying to repair some of the damaged walls in the bedrooms and bathrooms. The Director of Maintenance indicated the maintenance department is trying to repair and fix one wing at a time. The Director of Maintenance indicated he does make rounds but did not document when he made rounds or his findings. Interview with the ADNS on 7/2/24 at 3:19 PM identified she was not aware of the resident bedroom floors with stains, dirt, debris, discoloration and/or wax build up on the floors, and the privacy and window curtains dirty with brown stains. The ADNS indicated she will discuss the issues with the DNS, the Housekeeping Director, and RN #1. The ADNS indicated an in-service will be given to the housekeeping staff, and the nursing department. Interview with the DNS on 7/3/24 at 4:00 PM identified she was not aware of the issues. The DNS indicated that going forward there will be a meeting with the Director of Maintenance, the Director of Housekeeping, and RN #1 regarding the expectation of a home like environment. Although attempted, an interview with RN #1 and the Director of Housekeeping was not obtained. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Infection Preventionist position description identified the Infection Preventionist (IP) serves as the facility's Infection Prevention and Control Officer and functions as a practitioner, resource, consultant, educator, and facilitator for all staff in all departments focusing on the following areas: Infection Prevention & Control Activities Outcome & process Surveillance Outbreak Management & Reporting Requirements Employee Health To maintain a safe environment for facility residents and personnel. Review of the facility infection prevention rounds identified each center will have an effective Infection Control/Environmental Rounds Program in place. Rounds will be conducted monthly by the Infection Prevention Committee and appropriate department heads. Review of the Janitor/Custodian position description identified responsible for performing routine tasks to ensure the cleanliness of assigned areas of the facility. Review of the facility housekeeper position description identified responsible for performing routine tasks to ensure the cleanliness of assigned areas of the facility. Review of the facility engineering personnel/maintenance worker position description identified repairs and maintains the facility's equipment and buildings.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 46040 Based on observation, record review and interviews for 1 of 4 residents (Resident #78) who was on a secured locked unit and wore a wander guard, the facility failed to ensure the residents wander guard was changed when it expired, failed to investigate and implement interventions after Resident #78 was able to exit the secured locked unit on [DATE]; and failed to provide adequate supervision and devices to prevent the resident from exiting the secured locked unit on [DATE] when the resident accessed the elevator on the 4th floor, (secured locked unit), took the elevator to the 1st floor, and walked out the front door unsupervised. These failures resulted in a finding of Immediate Jeopardy. The findings include: Resident #78 was admitted to the facility in [DATE] with diagnoses that included dementia and traumatic brain injury. A fall risk evaluation, done upon admission in ,d+[DATE], identified Resident #78 was at high risk to fall due to a history of multiple falls prior to admission and use of multiple sedative, cathartic, and psychotropic medications. An elopement evaluation on admission, dated ,d+[DATE], identified Resident #78 was at high risk for elopement due to a physical ability to leave the facility, cognitive impairment, inability to make informed decisions about leaving the facility, and disorientation. Resident #78 had a wander guard device placed. The care plan dated [DATE] identified Resident #78 had impaired cognitive thought processes due to dementia that included inattention and disorganized thinking and was at risk for elopement and wandering. Interventions included to keep the resident's routine as consistent as possible to decrease confusion and the use of a wander guard device. Further, the care plan indicated the resident was at risk to fall. The care card, not dated, identified that Resident #78 was to have appropriate footwear on including non-skid socks and non-skid soles on shoes/sneakers while ambulating and non-skid socks on at bedtime. A psychiatric note dated [DATE] identified that staff had reported Resident #78 had periods of exit seeking behaviors and difficulty with redirection, the resident was cognitively impaired, was confused, was alert to person only, had confabulatory speech, had delusions that included confabulatory false fixed ideations, had poor insight, poor judgement, and impaired short-term memory and poor long term memory. A psychiatric note dated [DATE] identified Resident #78 had poor insight and judgement. The physician's orders dated [DATE] directed behavior monitoring for elopement every shift, and the use of a wander guard, check for expiration date every 7 days and check for function every 11:00 PM - 7:00 AM shift and as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility documentation identified Resident #78 resided on the 4th floor, a secured locked unit. Review of the March, April and [DATE] MARs identified Resident #78's wander guard had been checked for expiration by licensed staff weekly, however, documented on the MARs was an expiration date of [DATE] for the wander guard. The quarterly MDS assessment dated [DATE] identified Resident #78 had severely impaired cognition. Review of the [DATE] MAR identified Resident #78's wander guard had been checked for expiration by licensed staff on [DATE], [DATE], [DATE], and [DATE], however, documented on the MAR was an expiration date of [DATE] for the wander guard (8 months expired). The nurse's note dated [DATE] at 12:36 PM, written by the RN Supervisor (RN #3), entered as a late entry on [DATE] identified that Resident #78 wandered off the unit and was found on the 1st floor near the kitchen area. (This is in conflict with security camera footage that identified Resident #78 left the 4th floor via a stairwell to the 1st floor unsupervised from 8:11 PM - 8:26 PM, not 12:36 PM.) Although Resident #78 eloped the 4th floor secured unit during the 3:00 PM - 11:00 PM shift on [DATE], LPN #7 documented no elopement behaviors during the 3:00 PM - 11:00 PM shift on the MAR. Review of the clinical record failed to identify documentation regarding how Resident #78 was able to leave the secured unit or new interventions to monitor the resident's location on or following the [DATE] elopement from the secured locked unit on the 4th floor to the 1st floor on [DATE]. The nurse's note dated [DATE] by LPN #12 identified Resident #78 had been placed on every 15-minute checks for the 3:00 PM - 11:00 PM shift only however the clinical record failed to identify any documentation related to 15-minute checks being completed. In a 2nd elopment in 3 days, the nurse's note dated [DATE] at 2:00 PM by LPN #3 identified Resident #78 had been observed in the lobby (1st floor) by staff. The note further identified that Resident #78's wander guard was replaced, and Resident #78 was placed on 1:1 observation from 7:00 AM - 11:00 PM and every 15-minute checks from 11:00 PM - 7:00 AM. Interview with RN #3 on [DATE] at 9:11 AM identified he was the RN Supervisor on [DATE] during the 3:00 PM - 11:00 PM shift. RN #3 identified that Resident #78 was found on the 1st floor near the kitchen on [DATE] at approximately 9:00 PM by NA #5 but could not identify how Resident #78 was able to leave the secured unit. RN #3 identified he was notified of the incident by LPN #7, who was assigned to Resident #78. RN #3 identified the wander guard should have been changed at time it expired on [DATE], and that it should have been changed following the 1st elopement attempt on [DATE] as the wander guard can malfunction or lose battery function if not changed timely. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #7 on [DATE] at 12:54 PM identified she was the nurse assigned to Resident #78 on [DATE] during the 3:00 PM - 11:00 PM shift. LPN #7 identified that she was in another resident's room administering medications when she was notified by NA #5 that Resident #78 was found on the 1st floor near the kitchen around 9:00 PM. LPN #7 identified that Resident #78 had not been exit seeking during her shift, and that she spoke with Resident #78 and asked Resident #78 if he/she knew the code to leave the secured unit, which the resident did not. LPN #7 brought Resident #78 to the exit doors by the elevators, checked the function of the wander guard by entering the 4th floor elevator with Resident #78, and the alarm box for the wander guard did beep, however, the elevator did not lock and allowed LPN #7 and Resident #78 to operate the elevator to the 1st floor and then back up to the unit. LPN #7 identified that while the elevators did not lock, since the alarm beeped, LPN #7 did not check further into the actual wander guard Resident #78 was wearing to see if there were any issues with the it, including the expiration date, since the beep would mean the wander guard was functioning, even if the elevators did not lock. LPN #7 identified she notified RN #3 of the situation and was told by RN #3 he contacted the DNS that Resident #78 was to be placed on 1:1 monitoring. LPN #7 identified she did not complete 1:1 monitoring of Resident #78's location during her shift and was unable to identify who was assigned to complete the 1:1 monitoring. LPN #7 identified she did not notify any other facility staff, including maintenance staff, of the issue with Resident #78's wander guard, since she felt notification to RN #3 was sufficient. LPN #7 identified she did not document the residents elopement behaviors or the attempted elopement incident on [DATE] as she also felt this was addressed by her notification to RN #3. Interview with LPN #3 on [DATE] at 11:55 AM identified she was the charge nurse assigned to Resident #78's secured unit on [DATE] when the resident exited the unit unsupervised. Resident #78 was able to get off of the secured unit by following visitors to the elevator, which should have locked once Resident #78 attempted to use it, but Resident #78's wander guard was not working properly, and did not lock down the elevator, allowing the resident to leave the secured unit. LPN #3 identified that Resident #78's wander guard worked in some areas of the facility and not others, based on the investigation by LPN #3 and the DNS, but LPN #3 did not identify the specific areas that the wander guard failed to work. LPN #3 identified that the wander guard did not work to lock down the elevator on the secured locked unit, and Resident #78 was able to leave the unit. Further, LPN #3 identified the wander guard had expired in [DATE] and she changed it after the incident on [DATE]. LPN #3 identified that wander guards should be changed upon expiration. Interview with the Receptionist on [DATE] at 10:00 AM identified she was assigned to work the reception desk on [DATE] and was also assisting with admissions. The Receptionist identified she witnessed RN #1 walking a resident back into the building and that she was told the resident had a wander guard on, but it did not alarm or lock the exit doors. Interview with the Administrator on [DATE] at 10:12 AM identified he was aware Resident #78 had 2 incidents involving leaving the secured unit on the 4th floor to the 1st floor on [DATE] and [DATE]. The Administrator identified he had reviewed the security footage following the [DATE] attempt when he was made aware of an additional attempt on [DATE], 3 days prior. The Administrator identified that with both attempts, Resident #78 remained in the building and did not leave the lobby area (This is in conflict with the surveillance video that showed Resident #78 exiting the front door and being [NAME] back into the facility by RN #1). A request was made by this surveyor to review the security footage of the [DATE] and [DATE] incidents. The footage was observed with the Administrator identified the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of the security camera footage on [DATE] identified the following:. -At 8:10 PM Resident #78 walking toward the end of the 4th floor secured unit. At 8:13 PM Resident #78 walking down a flight of stairs located in the 1st floor stairwell. Resident #78 turns around to walk back up the stairs. At 8:16 PM Resident #78 is walking down the flight of stairs in the stairwell and exits the stairwell walking through a hallway on the 1st floor and towards to the main elevators. -At 8:18 PM Resident #78 pressed the up button and entered the elevator. At 8:24 PM Resident #78 walked out of the elevator on the 1st floor and through a set of double doors where the facility laundry and kitchen areas are located. -From 8:24 PM - 8:26 PM Resident #78 remained out of camera view in the laundry and kitchen areas. -At 8:26 PM NA #5 was seen entering the double doors in the laundry and kitchen areas and escorted Resident #78 towards the elevator and back to the 4th floor at 8:27 PM. Based on review of this security camera footage, Resident #78 was able to leave the 4th floor and was unsupervised in the facility from 8:11 PM - 8:26 PM, a total of 15 minutes. Observation of the security camera footage on [DATE] identified the following:. At 10:39 AM Resident #78 was seen standing at the 4th floor doors that give access to the elevator. A visitor exited the elevator to the 4th floor unit. -At 10:40 AM Resident #78 pressed the down button for the elevator and entered the elevator after the doors opened. -At 10:41 AM Resident #78 was observed exiting the 1st floor elevator and walked towards the lobby. -At 10:41 AM the Receptionist is seated at the reception desk, within direct eyesight of the exit door (approximately 6 feet) and the HR Director and Administrator are standing to the side of the reception desk facing the area of the front entrance. -At 10:41AM Resident #78 was seen walking towards the front entrance, directly passing the Receptionist, Administrator, and HR Director, through the initial exit door which did not appear to lock or alarm, and into the vestibule. -At 10:42 AM RN #1 was seen entering the facility with Resident #78. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator immediately following the security camera footage identified that on [DATE], Resident #78 was able to access a back stairwell outside of camera view, descend 4 flights of stairs, and accessed the 1st floor. The Administrator identified that the 4th floor unit has 3 access stair wells, all secured by the wander guard system. The Administrator also identified while he reviewed the camera footage at the time of the [DATE] incident, he did not realize that that Resident #78 had gotten outside the building. The Administrator further identified that Resident #78's wander guard failed, which allowed him/her to be able to access the stairwell on the 4th floor on [DATE] as well as leave the building on [DATE]. Areas that Resident #78 had access to when the resident eloped the 4th floor on [DATE] and when he/she eloped the facility on [DATE] included the following. On the 1st floor, the resident had access to the kitchen area, oxygen storage area, maintenance area, and nursing supply storage and equipment storage areas. The kitchen area included a large walk-in refrigerator and freezer, large industrial gas burner stove/ovens and dishwasher areas with sanitizing chemicals. The 1st floor also included the location of the maintenance office with equipment. In addition, the 1st floor has a total of 8 separate exit doors. The 1st floor also had 3 additional access points to the facility basement, which include the facility boiler room, the laundry room, the electrical room, and main mechanical room. When the resident eloped the facility on [DATE], the resident had access to the facility parking lot which provided direct access to 2 city roads, and the main access road was visible from the parking lot. The facility is also located in close proximity to a large parking lot used for medical offices, a private school, and a church. Interview with RN #1 (IP Nurse) on [DATE] at 11:23 AM identified that he was leaving the facility for an appointment sometime between 10:30 AM - 11:00 AM on [DATE] and although he did not see the resident exit the facility, he saw Resident #78 outside of the facility. RN #1 identified he had observed Resident #78 standing approximately 5 feet from the outside exit doors of the facility on a sidewalk. Interview with the Maintenance Technician on [DATE] at 11:27 AM identified he was outside the facility working in the parking lot approximately 15 feet from the outside entrance doors on [DATE] when he saw RN #1 pull his vehicle up to the sidewalk near the entrance and saw a resident standing in the walkway. The Maintenance Technician identified he saw the resident there prior to RN #1 pulling up. The Maintenance Technician identified he saw RN #1 park his vehicle, get out, and walk Resident #78 back into the building. The Maintenance Technician identified he did not know Resident #78 was able to exit the building with a wander guard, or that the resident was able to leave the secured unit, until he was notified later that day. Review of the clinical record failed to reflect that every 15-minute checks or 1:1 monitoring had been initiated after Resident #78 was able to exit the 4th floor secured locked unit on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the user manual for the Advantage 1000DE system, the wander guard system used by the facility, directed that the transmitter should have an annual battery change, and that once the expiration date of the transmitter had been reached, they would not be repaired or have the warranty extended. The manual also directed that the advanced security mode feature allowed for doors attached to the system to remain locked when a monitored resident with a transmitter approached. The manual directed that when a resident with a transmitter was in range of the system, any doors connected to the system would lock and be accompanied by a beep. The facility policy on the Wander Guard Secure Care Alarm directed that residents identified as an elopement risk would have a wander guard applied to ensure their safety and directed that the device would be checked for placement every shift, function once daily and expiration and/or battery life weekly and these would be documented in the TAR. The policy further directed that any device that had expired or malfunctioned would be discarded or replaced. The facility policy on elopement directed that residents of the facility would be accounted for at all times, and any resident identified as missing would require protocol that would include to announce a designated code alert for a missing person and initiate a missing person report; assign staff to begin an organized search of the facility and grounds, and notify the DNS, Administrator, provider, and resident representative. The facility policy on environment of care related to the Alzheimer's Special Care Unit (located on the 4th floor) directed that the facility Wander Guard system was worn by residents who were determined to be high risk of elopement from the unit, and that the system would not allow exit from the facility's entrances and exits. The facility policy on 1:1 monitoring directed that a licensed nurse, the DNS, and/or the Administrator was responsible to place a resident on 1:1 observation if the safety of the resident was at risk. The policy further directed that facility guidelines for 1:1 observation included unsafe wandering or exit seeking behavior on or off the unit. The policy further directed that staff members were responsible to report any resident behaviors that posed a potential for harm to the resident, and the person who becomes aware of the situation was to stay with the resident and call for assistance, and that the licensed nurse was to evaluate the resident and ensure that the resident was not left alone and assign a designated person to monitor the resident 1:1. The policy also directed the DNS/Administrator, attending physician, and resident representative would be notified and that staff responsible for the resident would be educated by the licensed nurse on 1:1 observation.