STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075381	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATER'S EDGE CENTER FOR HEALTH & REHAB	**111 CHURCH STREET MIDDLETOWN, CT 06457**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0678 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation and interviews for two of three licensed nursing staff who responded to a medical emergency, the facility failed to maintain current CPR certification. The findings include: Review of the facility records identified that LPN #1 date of hire was [DATE] and LPN #2 date of hire was [DATE]. Further review of the facility records failed to identify current CPR certification for LPN #1 and LPN #2. Interview with DON on [DATE] at 1:00 PM identified that staff development nurse was responsible to maintain current CPR certification for the licensed nursing staff. DON identified that she did not heave a current CPR certification for LPN #1 and LPN #2, however the RN #1 (RN supervisor) was CPR certified. Interview with RN #2 on [DATE] at 1:52 PM identified that newly hired nurses were asked to provide current CPR certification card at the orientation. RN #2 identified that LPN #1 and LPN #2 came on board after she completed her last audit. RN #2 identified that she did not have LPN #1's and LPN #2's CPR certification card on file. RN #2 indicated that she did not have it because she had not completed another audit. RN #2 identified that she completed quarterly audits of CPR certification cards and last audit she conducted was on [DATE]. Interview with DON on [DATE] at 9:20 AM identified that LPN #1 and LPN #2 completed CPR certification on [DATE]. CPR policy identified that DON was responsible to have sufficient staff available on all shifts that were CPR certified, to provide CPR certification/recertification for licensed staff and to identify all staff that were CPR certified.
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 clinical record reviews, review of facility documentation and interviews for one sampled resident (Resident #1) who was reviewed for accidents, the facility failed to ensure Resident #1 received appropriate diet consistency. The findings include: Resident #1's [DIAGNOSES REDACTED].#1 had moderately impaired cognition, was independent with eating with set up help only, required mechanically altered diet (required change in texture of food or liquids, e.g. pureed foods, thickened liquids) and required therapeutic diet. The Resident Care Plan dated 7/21/20 identified Resident #1 had dysphagia related to coughing, difficulty swallowing. Interventions directed to provide diet consistency and fluid consistency as ordered by physician. A physician's orders [REDACTED]. Review of the meal ticked dated 10/15/20 identified that Resident #1 was to receive soft cooked, ground hot vegetables in a separate bowl for supper. The nurse's note dated 10/15/20 at 10:46 PM identified LPN #1 was called to Resident #1's room. Upon entering the room LPN #1 noticed Resident #1 was coughing. LPN #1 asked if Resident #1 was okay and Resident #1 was able to joke with LPN #1. Resident #1 continued coughing and talking. Oxygen was applied. LPN #1 left the room to check on the oxygen order and to obtain the vital sign machine and was called back to Resident #1's room by NA #1 due to Resident #1 coughing again. RN #1 was called STAT to Resident #1's room. Resident #1 was sat up on the edge of the bed and [MEDICATION NAME] maneuver was performed. Review of the facility investigation identified that Resident #1 had an order for [REDACTED].#1 received coleslaw which was not on his/her meal ticket. Coleslaw, which was considered a raw vegetable, should have been avoided on ground diet. Interview with NA #1 on 10/20/20 at 10:23 AM identified that she delivered the dinner tray to Resident #1 on 10/15/20. NA #1 indicated that the coleslaw was on the tray, however she did not know that Resident #1 was not supposed to have coleslaw on the ground diet. NA #1 identified that coleslaw was not on his/her ticket, however vegetables were, so she thought coleslaw was a vegetable because it was ground up. NA #1 indicated that she was educated after the incident that residents on ground diet cannot have raw vegetables such as coleslaw. Interview with Cook #1 on 10/20/20 at 12:24 PM identified that he was the one who prepared Resident #1 meal. Cook #1 indicated that the caller called a ground diet for Resident #1 and Cook #1 identified that he was pretty sure Resident #1 was all ground diet which meant Resident #1 was to receive all ground meats, soft vegetables and mushed potatoes with gravy. Cook #1 identified that he served coleslaw, a fine chopped coleslaw, ground meat on hamburger roll with gravy on top of the meat for Resident #1 on 10/15/20. Cook #1 indicated that the checker checked the tray to make sure that the diet was correct. Further Cook #1 indicated that there were checks in place to ensure residents received the correct diet. The caller was to call the diet to the cook, the cook prepared the meal and placed the meal on the tray, then the checker was to check if everything was consistent with the meal ticket and put the tray on the truck that went to the unit. Then once the truck arrived on the unit NA or a nurse was to deliver the tray to a resident and check if the diet consistency was correct before delivering the tray to a resident. Cook #1 indicated that both the caller and the checker were inexperienced. Further Cook #1 identified that if Resident #1 was on a ground diet then he/she should have not been served the coleslaw on his/her supper tray. Resident #1 was not to be served a raw vegetable like coleslaw. Interview with Speech Therapist #1 on 10/20/20 at 1:27 PM identified that coleslaw was not allowed on ground diet because coleslaw was a raw vegetable. Interview and review of the clinical record with DON on 10/20/20 at 1:30 PM identified that Resident #1 did not receive correct diet, and the meal tray did not match the meal ticket. Therefore, Resident #1's meal was not prepared per the consistency of his/her diet. The dietary staff and the nursing staff were responsible to ensure that the meal provided to Resident #1 was consistent with his/her diet order. The dietary was re-educated regarding appropriate preparation for all approved diets, to ensure residents diet, meal ticket and meal tray all match before placing on meal cart or delivering to resident. The nursing staff was re-educated regarding matching resident's diet to ticket and meal tray. If either did not match the resident's tray was to be removed, kitchen notified to prepare the appropriate meal according to the resident's diet and deliver new tray per resident's diet consistency and preference. Mechanically altered/ground- dysphagia level 2 diet policy identified that this diet consisted of foods which were moist, soft textured and easily formed into a bolus. Meats, vegetables and fruits were ground, moist with some cohesion. Small pasta was permitted. No corn, rice, grapes, crunchy or hard foods such as cold cereal, pancakes, waffles or rolls were allowed, bread without crust was allowed.

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

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.