

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab Farmington Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 269 Farmington Ave Plainville, CT 06062	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure a complete and accurate medical record to include a physician order for a foley catheter insertion after a fall, and to include a time duration to wait before reinserting a foley catheter. The findings include:</p> <p>Resident #1 had a diagnosis of retention of urine, after care following surgery of genitourinary system, and neuromuscular dysfunction of the bladder. The Resident Care Plan (RCP) dated 4/16/2024 identified Resident #1 had an indwelling catheter. Interventions directed to provide indwelling catheter care. The admission Minimum Data Sheet assessment dated [DATE] identified Resident #1 had a BIMS of 3 (severely impaired cognition) and had a catheter.</p> <p>The physician order dated 4/18 /2024 directed that if the foley catheter was pulled out to not replace it, and to not send Resident #1 to the hospital.</p> <p>The nursing note dated 4/21/2024 at 3:46 AM identified an unwitnessed fall; Resident #1 was observed lying on his/her back at around 1 AM and no injuries were noted. Resident #1 had baseline mentation, positive range of motion, denied hitting his/her head and Resident #1 had pulled his/her foley catheter out. The note identified a new catheter was inserted by the charge nurse. The APRN and family was updated regarding the fall.</p> <p>Record review failed to identify a physician's order that directed to re-insert the foley.</p> <p>The interview and record review with RN #1 on 4/28/25 at 12:24 PM identified she would not reinsert a foley or instruct the charge nurse to reinsert a foley unless there was a physician order that directed to. RN #1 stated she must have forgotten to write the order, and she should have written an order after speaking with the APRN regarding the fall.</p> <p>Interview and record review with the Administrator, the DNS and Regional RN # 333 on 4/28/25 identified RN #1 should have written the physician order in the clinical record that directed to reinsert the foley catheter. Interview failed to identify why the order was not written.</p> <p>a.</p> <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nursing note dated 4/29/2024 at 11:42 AM identified Resident #1's foley was noted to be out, and the supervisor, family, APRN, and ADNS were notified. A new order was obtained that directed to reinsert the foley catheter if Resident #1 did not void.</p> <p>The physician order dated 4/29/2024 directed staff to reinsert the foley catheter if the resident does not void, and if the resident refuses the catheter, to not reinsert.</p> <p>Additional record review failed to identify the order dated 4/29/2024 directed the length of time (example: 4, 6 or 8 hours) to wait for Resident #1 to void, before reinserting the catheter.</p> <p>The nursing note dated 4/29/2024 at 8:35 PM (8 hours, 53 minutes after the note that indicated the foley catheter was out) identified a foley catheter was attempted to be placed but was unsuccessful. The APRN was notified at 6:35 PM (approximately 6 hours and 53 minutes after the foley was noted to be out) and an order was obtained to transfer Resident #1 to the hospital for evaluation. The family was made aware and was in agreement with transferring the resident.</p> <p>Interview with APRN # --- was not obtained during survey.</p> <p>The interview and record review with RN #1 on 4/28/25 at 12:24 PM identified although she thought six (6) hours was an acceptable length of time to wait for Resident #1 to void before attempting to reinsert the catheter, RN #1 was unable to identify the order directed a length of time to wait. RN #1 indicated orders would usually direct the staff how long to wait for the resident to void before reinserting a catheter.</p> <p>Interview and record review with the Administrator, the DNS and Regional RN #1 on 4/28/25 identified although they thought six (6) hours was an appropriate length of time to wait to see if the resident voided before attempting to insert another foley catheter, interview identified the physician order should have included directions that indicated how long staff should wait before attempting to reinsert the catheter. Interview failed to identify why the time frame was not included in the orders.</p> <p>Although requested, a policy was not provided regarding physician orders.</p>