

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab Saybrook		STREET ADDRESS, CITY, STATE, ZIP CODE 1775 Boston Post Rd Old Saybrook, CT 06475	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of three (3) residents (Residents #1, #2 and #3) reviewed for medication administration, the facility failed to notify the Nurse Practitioner (NP) timely of medication omissions. The findings include:</p> <p>1. Resident #3 was admitted to the facility on [DATE] with diagnoses including a fracture of the left femur and hypothyroidism.</p> <p>The Resident Care Plan (RCP) dated 1/8/25 identified that Resident #3 required staff assistance with Activities of Daily Living (ADLs) related to impaired mobility with interventions included to provide staff assistance as needed.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and was independent with eating, required substantial assistance with bed mobility and was dependent on staff for transfers.</p> <p>a. A physician's order dated 1/7/25 directed to administer Cozaar (anti-hypertensive medication) 50 milligram (mg) tablet by mouth once daily, Pravachol 40 milligram (mg) tablet by mouth once daily for cholesterol, Lexapro 20 milligram (mg) tablet by mouth once daily for depression.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #3's Cozaar 50 mg, was not administered on 1/8/25 at 9:00 AM, Pravachol 40 milligram (mg) tablet, Lexapro 20 milligram (mg) tablet with documentation noting that it was held and to see nurse's notes.</p> <p>A nurse's note dated 1/8/25 at 11:32 AM identified that Cozaar 50 mg, Pravachol 40 milligram (mg) tablet, Lexapro 20 milligram (mg) table was held due to the resident being newly admitted and the facility was awaiting delivery of the medication from the pharmacy.</p> <p>Review of nurse's notes dated 1/8/25 failed to identify that the provider had been notified of the missing doses of Cozaar, Lexapro or Pravachol on 1/8/25.</p> <p>b. A physician's order dated 1/7/25 directed to administer Synthroid 100 microgram (mcg) tablet by mouth once daily in the morning for thyroid replacement.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #3's Synthroid 100 mcg tablet was not administered on 1/8/25 at 6:30 AM with documentation directing to see nurse's notes. On 1/13/25 the MAR was blank with no documentation indicating that the Synthroid 100 mcg had been administered. On 1/16/25 the MAR identified that Synthroid 100 mcg was not administered as the resident was sleeping. On 1/22/25 the MAR was blank with no documentation indicating that the Synthroid 100 mcg was administered.</p> <p>A nurse's note dated 1/8/25 at 5:50 AM identified that Synthroid 100 mcg had not yet arrived from the pharmacy. No further nurse's notes identified that the provider was notified of the missed dose.</p> <p>Review of nurse's notes from 1/13/25 failed to identify documentation as to why the Synthroid 100 mcg had not been administered or that the provider was notified of the missed dose.</p> <p>Review of nurse's notes from 1/16/25 failed to identify documentation that the provider was notified of the missed dose of Synthroid 100 mcg.</p> <p>Review of nurse's notes from 1/22/25 failed to identify documentation as to why the Synthroid 100 mcg had not been administered or that the provider was notified of the missed dose.</p> <p>c. A physician's order dated 1/8/25 directed to administer Omeprazole (used to treat heartburn, stomach ulcers and/or gastroesophageal reflux disease) 20 milligrams (mg) capsule by mouth once daily.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #3's Omeprazole 20 mg administration on 1/13/25 at 6:30 AM was blank with no documentation indicating that the Omeprazole 20 mg had been administered. On 1/16/25 the MAR identified that Omeprazole 20 mg was not administered as the resident was sleeping. On 1/22/25 the MAR was blank with no documentation indicating that the Omeprazole 20 mg was administered.</p> <p>Review of nurse's notes from 1/13/25 failed to identify documentation as to why the Omeprazole 20 mg had not been administered or that the provider was notified of the missed dose.</p> <p>Review of nurse's notes from 1/16/25 failed to identify documentation that the provider was notified of the missed dose of Omeprazole 20 mg.</p> <p>Review of nurse's notes from 1/22/25 failed to identify documentation as to why the Omeprazole 20 mg had not been administered or that the provider was notified of the missed dose.</p> <p>Interview with LPN #2 on 1/23/25 at 12:56 PM identified that although the provider should be notified for all missed doses of medication, she did not notify the provider on 1/8/25 when Resident #3 was not administered Synthroid 100 mcg due to it not being available from the pharmacy, stating she instead notified the oncoming nurse that the medication was unavailable. Additionally, she identified that she was unable to recall why both the Synthroid 100 mcg and the Omeprazole 20 mg weren't signed off as administered on 1/13/25 and 1/22/25, stating that if she administered them to Resident #3, she should have signed them off.</p> <p>Although attempted, an interview with RN #2 was not obtained.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #2 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia (uncontrollable and involuntary movements) and constipation.</p> <p>The Nursing Admission assessment dated [DATE] identified Resident #2 was alert and oriented to person, place and time with good memory recall and required staff assistance of two (2) for transfers and ambulation.</p> <p>The Resident Care Plan (RCP) dated 1/23/25 identified that Resident #2 required assistance with Activities of Daily Living (ADLs) related to impaired mobility secondary to Parkinson's disease with interventions included to provide staff assistance as needed.</p> <p>a. A physician's order dated 1/21/25 directed to administer Carbidopa-Levodopa 25-100 milligram (mg) tablet by mouth three (3) times daily for Parkinson's disease.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #2's Carbidopa-Levodopa 25-100 mg was not administered on 1/21/25 at 9:00 PM with documentation directing to see nurse's notes.</p> <p>A nurse's note dated 1/21/25 at 11:06 PM identified that Carbidopa-Levodopa 25-100 mg was held due to the facility awaiting delivery of the medication from the pharmacy.</p> <p>Review of nurse's notes dated 1/21/25 failed to identify documentation that the provider was notified of the missed dose of Carbidopa-Levodopa 25-100 mg.</p> <p>Interview with LPN #4 on 1/23/25 at 12:19 PM identified that Resident #2 did not receive the first dose of Carbidopa-Levodopa 25-100 mg on 1/21/25 because it was unavailable, and RN #3 (nursing supervisor) and herself didn't have access to the Omnicell (automated machine for medication management). She reported that although she didn't notify the provider and she should have, RN #3 was aware the medication was unavailable, and she thought RN #3 was going to call the provider to report the missed dose but was unsure why the provider notification wasn't documented in the clinical record.</p> <p>Although attempted, an interview with RN #3 was not obtained.</p> <p>b. A physician's order dated 1/21/25 directed to administer Linzess 290 microgram (mcg) capsule by mouth once daily for constipation.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #2's Linzess 290 mcg was not administered on 1/22/25 or 1/23/25 at 6:30 AM with documentation directing to see nurse's notes.</p> <p>A nurse's note dated 1/22/25 and 1/23/25 at 5:42 and 5:46 AM identified that Resident #2's Linzess 290 mcg was not administered as they were awaiting the delivery of the medication from the pharmacy.</p> <p>Review of nurse's notes dated 1/21/25 failed to identify documentation that the provider was notified of the missed dose of Carbidopa-Levodopa 25-100 mg.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with LPN #2 on 1/23/25 at 12:56 PM identified that Resident #2's Linzess had not yet arrived from the pharmacy for the 1/22/25 dose and reported that although the provider should have been notified of the missed dose, she didn't notify the provider and instead passed it on to the 7:00 AM to 3:00 PM shift and requested they call the pharmacy to check on the status of the medication.</p> <p>Interview with LPN #3 on 1/23/25 at 2:14 PM identified that Resident #2's Linzess was not available on 1/23/25 and although she should have notified the provider of the missed dose, she forgot.</p> <p>3. Resident #1 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), atrial fibrillation (irregular heartbeat) and congestive heart failure (build-up of blood in other parts of the body due to the hearts inability to pump blood adequately to keep up with the body's needs).</p> <p>The Nursing Admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place and time with good memory recall and required assistance for transfers and ambulation.</p> <p>a. A physician's order dated 1/22/25 directed to administer Apixaban (a blood thinner used to prevent serious blood clots from forming) 5 milligram (mg) tablet by mouth twice daily for atrial fibrillation.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #1's Apixaban 5 mg was not administered on 1/22/25 at 9:00 PM with documentation directing that the medication was held and to see nurse's notes.</p> <p>A nurse's note dated 1/22/25 at 12:43 AM identified that Resident #1's Apixaban 5 mg was not administered as the medication had not yet arrived from the pharmacy.</p> <p>b. A physician's order dated 1/22/25 directed to administer Carvedilol (used to treat high blood pressure and heart failure) 12.5 milligram (mg) tablet by mouth twice daily for congestive heart failure.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #1's Carvedilol 12.5 mg was not administered on 1/22/25 at 9:00 PM with documentation directing to see nurse's notes.</p> <p>A nurse's note dated 1/23/25 at 12:44 AM identified that Resident #1's Carvedilol 12.5 mg was not administered as the medication had not yet arrived from the pharmacy.</p> <p>c. A physician's order dated 1/22/25 directed to administer Allopurinol (used to treat gout and certain types of kidney stones) 200 milligram (mg) tablet by mouth at bedtime for congestive heart failure.</p> <p>Review of the Medication Administration Record (MAR) for January 2025 identified that Resident #1's Allopurinol 200 mg was not administered on 1/22/25 at 9:00 PM with documentation directing to see nurse's notes.</p> <p>A nurse's note dated 1/23/25 at 12:42 AM identified that Resident #1's Allopurinol 200 mg was not administered as the medication had not yet arrived from the pharmacy.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of nurse's notes from 1/22/25 to 1/23/25 failed to identify documentation that the provider was notified of the missed doses of Apixaban 5 mg, Carvedilol 12.5 mg and Allopurinol 200 mg on 1/22/25 at 9:00 PM.</p> <p>Interview with LPN #3 on 1/23/25 at 2:14 PM identified that there's not enough nursing staff to handle admissions, stating she is responsible for the medication pass and treatments on 36 residents and by the time the admission is completed, and the medications are ordered, it's often past the allotted time to administer the medication. She reported that if the medication is unavailable, she will notify the nursing supervisor if time allows but identified that she could not recall who the nursing supervisor was on the 3:00 PM to 11:00 PM shift on 1/22/25 and did not think she notified them of Resident #1's missed doses of medications at 9:00 PM that night, stating if she did she should have documented it in the clinical record. Additionally, she reported that although she should have, she did not notify the provider of the missed doses of medication.</p> <p>Interview with the DNS on 1/23/25 at 10:55 AM identified that although the facility has an Omnicell that stores medications for new admissions, many medications are not available in stock. She identified that she was not aware of the missed medications for Residents #1, #2 and #3 and was unsure why the provider wasn't notified, but stated it is her expectation that the nurse on duty notifies the provider of any unavailable or missed medications for a resident as soon as possible to get new orders and that they document their communication in the clinical record. She identified that all nurses should be double checking that all medications are signed off prior to the end of their shift and that it's not acceptable to be documenting that the medication is not available or that the medication was held due to the resident sleeping without any follow-up documentation as to whom they notified.</p> <p>Interview with NP #1 on 1/23/25 at 12:29 PM identified that anytime medications are unavailable, or doses are missed, it is her expectation that a provider is notified by the facility so an alternative medication can be ordered, or an order can be obtained to give the medication late, if applicable. She identified that for Resident #3, although not detrimental, the Cozaar, Lexapro and Synthroid should not have been missed. For Resident #2, she identified that the resident has been inconsistent with taking both the Carbidopa-Levodopa and the Linzess prior to coming to the facility so she did not believe the missed doses were detrimental to the resident. For Resident #1, she identified that she would have preferred the resident to have gotten the Apixaban, Carvedilol and Allopurinol late rather than not at all but reported that missing one dose would not be detrimental to the resident.</p> <p>Although requested, a facility policy for provider notification of missed medication administration was not provided.</p> <p>Review of the Medication Error policy (undated) directed, in part, that all medication errors will be reported to the resident's physician and family. When a medication error is identified, the licensed nurse will determine the nature of the error and notify the physician and nursing staff will follow through with monitoring and any additional interventions as indicated by the physician. A medication error report will be completed and submitted to the Director of Nursing and the Director of Nursing will review the error with the consultant pharmacist to determine significance of the error. Follow-ups for in services are then provided as necessary to prevent reoccurrences.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</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** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of three (3) residents (Residents #8, #9 and #10) reviewed for showering, the facility failed to ensure Nurse Aide (NA) documentation was complete in the clinical record and for Resident #7 failed to retain medical records within the facility per policy. The findings include:</p> <p>1. Resident #8's diagnoses included dementia with behavioral disturbances, urinary tract infection and anxiety disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Mental Interview for Mental Status (BIMS) of four (4) indicative of severely impaired cognition and was dependent on staff for showering/bathing.</p> <p>The Resident Care Plan (RCP) dated 12/12/24 identified that Resident #8 required staff assistance with Activities of Daily Living (ADLs) due to impaired mobility and cognitive deficits related to dementia with interventions included assisting as needed to meet bathing, dressing, hygiene and toileting needs.</p> <p>Review of the facility shower list identified that Resident #8 was to receive showers on Mondays on the 3:00 PM to 11:00 PM shift.</p> <p>A physician's order dated 9/12/23 directed to complete a body audit on shower days by a licensed nurse weekly on Mondays on the 3:00 PM to 11:00 PM shift.</p> <p>Review of the January 2025 Documentation Survey Report (Nurse Aide Documentation) failed to identify that Resident #8 received a shower in January 2025 until 1/20/25 per the Shower/Bath documentation, although per physician's order, there should be documentation that Resident #8 received a shower on 1/6/25 and 1/13/25.</p> <p>2. Resident #9's diagnoses included depression and a history of falling.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with showering/bathing.</p> <p>The Resident Care Plan (RCP) dated 1/15/25 identified that Resident #9 required assistance with Activities of Daily Living (ADLs) due to self-care deficit related to impaired mobility with interventions that included assisting as needed to meet bathing, dressing, hygiene and toileting needs.</p> <p>Review of the facility shower list identified that Resident #9 was to receive showers on Mondays on the 3:00 PM to 11:00 PM shift.</p> <p>A physician's order dated 1/19/25 directed to complete a body audit on shower day every Sunday (does not identify shift).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the January 2025 Documentation Survey Report (Nurse Aide Documentation) failed to identify that Resident #9 received a shower in January 2025 per the Shower/Bath documentation, although per physician's order, there should be documentation that Resident #9 received a shower on 1/19/25.</p> <p>3. Resident #10's diagnoses included cerebral infarction (a stroke that affects blood flow to the brain), hemiplegia (partial paralysis) affecting the left non-dominant side, major depressive disorder and anxiety disorder.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Mental Interview for Mental Status (BIMS) of eleven (11) indicative of moderately impaired cognition and required setup assistance with showering/bathing.</p> <p>The Resident Care Plan (RCP) dated 12/31/24 identified that Resident #10 required assistance with Activities of Daily Living (ADLs) due to impaired mobility secondary to left hemiparesis after a cerebrovascular accident in 2020. Interventions included assisting as needed to meet bathing, dressing, hygiene and toileting needs.</p> <p>Review of the facility shower list identified that Resident #10 was to receive showers on Wednesdays on the 3:00 PM to 11:00 PM shift.</p> <p>A physician's order dated 9/8/24 directed to complete a body audit on shower days by a licensed nurse weekly on Sunday on the 3:00 PM to 11:00 PM shift.</p> <p>Review of the January 2025 Documentation Survey Report (Nurse Aide Documentation) failed to identify that Resident #10 received a shower in January 2025 per the Shower/Bath documentation, although per physician's order there should be documentation that Resident #10 received a shower on 1/5/25, 1/12/25 and 1/19/25.</p> <p>Interview with the DNS on 1/23/25 at 3:20 PM identified that the unit shower schedule days and times and the specified resident body audit on shower days orders should match up, stating she was unsure why the unit schedule differed from the body audit orders in the resident's clinical records (Resident #9 and #10). She identified that she expected that the Nurse Aides (NA's) are following the shower schedules and documenting weekly per policy whether the shower was given or if it was refused, stating no one should be documenting Not Applicable (NA) or leaving the task blank on the assigned day. She reported that if the shower was not given or the resident refused the shower, the assigned nurse should be notified at the time so the shower can be reassigned as soon as possible.</p> <p>4. Interview with the Administrator on 1/23/25 at 2:51 PM identified that although per policy, the facility is responsible for retaining medical records for seven (7) years, they were unable to locate the clinical record of Resident #7.</p> <p>Interview with the DNS on 1/24/25 at 3:54 PM identified that they were unable to locate the medical record for Resident #7.</p> <p>Review of the Bathing/Shower policy (undated) directed, in part, that each resident will be offered a full bath/shower at least weekly.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the CNA Flow Sheets (Resident Care Record) policy (undated) directed, in part, that the CNA will document the care provided to the resident for that shift by completing the entire flow sheet and all the approved coding and abbreviations shall be used. The CNA will document the resident's self-performance level, and the number of staff members needed for the task, the resident's mood/behavior, amount eaten, transfer device, number of feet walked, assistive devices for ambulation, bowel and bladder incontinence, type of bathing, communication, other devices and seating. Upon completion each CNA must initial in the appropriate box. The flow sheet is a part of the resident's medical record and will be used to assist in developing an individualized plan of care for the resident.</p> <p>Review of the Medical Records Retention policy (undated) directed, in part, that medical records will be retained for a minimum of seven (7) years from the date of the resident's discharge or last encounter, whichever is later.</p>