Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075070	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Saybrook	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)
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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Residents #1) who exhibited behavioral symptoms, the facility failed to notify the provider of medication omissions when the antianxiety medication was not available therefore six (6) doses were omitted. The findings include:Resident #1's diagnoses included catatonic disorder (a neuropsychiatric disorder that presents with abnormal motor, behavioral, and emotional responses which can include immobility, excessive movement and unusual postures or speech), major depressive disorder, anxiety disorder, delusional disorder and unspecified psychosis (psychotic symptoms that don't align with a specific psychotic disorder or mental illness). The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) indicating Resident #1 had some memory recall deficits and received antianxiety and hypnotic medications. The Resident Care Plan dated 12/5/25 identified Resident #1 was receiving antianxiety medication. Interventions included administering medication as directed by the provider and updating the provider of any concerns, complications or changes in condition. A physician's order dated 12/12/25 directed to administer lorazepam tablet 0.5 milligrams (mg), give 0.5 mg by mouth three (3) times daily for restlessness and catatonia. Review of the December 2025 Medication Administration Record (MAR) identified the lorazepam was not administered on 12/18/25 at 4:00 PM and 9:00 PM because the lorazepam was unavailable. Review of nurse's electronic MAR (eMAR) notes dated 12/18/25 failed to reflect documentation a provider was notified the lorazepam was not available and therefore two (2) doses were omitted. A physician's order dated 12/19/25 directed to discontinue the lorazepam three (3) times a day and start lorazepam tablet 0.5 milligrams (mg), give 0.5 mg by mouth four (4) times daily for restlessness and catatonia. Review of the December 2025 Medication Administration Record (MAR) identified the lorazepam was not administered on 12/25/25 at 4:00 PM and 8:00 PM, 12/26/25 at 4:00 PM and 8:00 PM and on 12/27/25 at 8:00 AM and 12:00 PM because the lorazepam was unavailable, therefore six (6) doses were omitted. Review of nurse's electronic MAR (eMAR) notes dated 12/25/25 through 12/27/25 identified the medication was not administered because the medication was not available and was on order, and the notes failed to identify a provider was notified. Interview with the psychiatric Advanced Practice Registered Nurse on 1/7/26 at 2:50 PM identified she was not aware of Resident #1 missing any doses of lorazepam, explaining a provider should have been notified, and another benzodiazepine could have been ordered as an alternative in the meantime due to the frequency the medication was scheduled and Resident #1's diagnosis of catatonia. Interview with the Regional Nurse, Registered Nurse (RN) #7, on 1/7/25 at 3:12 PM identified a provider should have been notified for all the missed doses of lorazepam for a possible alternative order. RN #7 explained the pharmacy should have been contacted to inquire if there were any issues and to require the medication STAT (immediately) and she was unable to find any (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation that had occurred. Review of the Medication Administration policy (undated) directed, in part, that all medications shall be administered safely and accurately in accordance with physician orders, facility protocols, and applicable state and federal regulations. For medications that are unavailable at the time of administration, notify the physician immediately and request guidance or an alternative order, inform the resident or their responsible party about the situation, check with the pharmacy or alternative suppliers to expedite delivery of the medication, document all actions taken in the resident's medical record and notify the supervisor.

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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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had behavioral symptoms of restlessness and impulsiveness, the facility failed to ensure the plan of care was reviewed and revised to address the addition of an anti-psychotic medication when the medication was ordered. The findings include:Resident #1's diagnoses included catatonic disorder (a neuropsychiatric disorder that presents with abnormal motor, behavioral, and emotional responses which can include immobility, excessive movement and unusual postures or speech), major depressive disorder, anxiety disorder, delusional disorder and unspecified psychosis (psychotic symptoms that don't align with a specific psychotic disorder or mental illness). The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) indicating Resident #1 had some memory recall deficits, required staff assistance with activities of daily living and received antianxiety and hypnotic medications. The psychiatric Advanced Practice Registered Nurse's (APRN) note dated 12/23/25 identified there were concerns Resident #1 may have undiagnosed bipolar disorder, depression, or significant trauma history as medical causes for catatonia were ruled out. The note directed that she would trial Abilify (an anti-psychotic medication) at a low dose, and she would be ordering Abilify 2 milligrams (mg) daily. A physician's order dated 12/23/25 directed to administer Abilify 2 mg tablet, give 2 mg bymouth one (1) time a day for delusional disorder (having false beliefs based on an incorrect interpretation of reality). The psychiatric APRN note dated 1/2/26 identified Resident #1 continued to exhibit restlessness and yelling out and the plan was to increase the Abilify to 5 mg daily for psychosis. A physician's order dated 1/2/26 directed to administer Abilify 5 mg tablet, give 5 mg bymouth one (1) time a day for psychosis. Review of the Resident Care Plan (RCP) from 12/23/25 through 1/7/26 failed to reflect documentation a care plan was put into place to address the use of the anti-psychotic medication, Abilify. Interview and clinical record review with both the Director of Nursing (DON) and the Regional Nurse, Registered Nurse (RN) #7, on 1/7/26 at 12:10 PM identified that for any resident on anti-psychotic medications, a care plan was required to guide the resident's plan of care, to include interventions on monitoring the resident for side effects and continued behaviors. They explained both the nursing staff and Minimum Data Set (MDS) Coordinator were responsible for the initiation of care plans and they were unsure why a care plan had not been developed when the Abilify had been ordered fifteen (15) days prior. They identified they discuss residents on psychotropic medications during their weekly risk meetings every Wednesday to ensure care plans and all required orders are put into place but Resident #1 must have been missed. Interview with the MDS Coordinator, RN #6, on 1/7/26 at 2:05 PM identified a care plan should have been developed for Resident #1 to target the use of the anti-psychotic medication. Review of the Care Planning policy dated 10/30/20 directed, in part, that a comprehensive and individualized plan of care will be developed for each resident. The care plan will guide caregivers to assist residents to achieve or maintain their highest practical level of well-being. A comprehensive care plan based on the identified needs, strengths and preferences of the resident will be developed no later than 7 days after the completion of the admission MDS. The care plan is developed by the Interdisciplinary Team (IDT) in collaboration with the resident and/or family/responsible party and the resident's physician. The care plan is reviewed and updated at least quarterly and as necessary to reflect changes in the residents' status.

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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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had a history of falls, the facility failed to ensure a Registered Nurse (RN) assessment was completed after three (3) of seven (7) falls and failed to ensure the resident was kept in place and not moved prior to the RN assessment. The findings include:Resident #1's diagnoses included catatonic disorder (a neuropsychiatric disorder that presents with abnormal motor, behavioral, and emotional responses which can include immobility, excessive movement and unusual postures or speech), major depressive disorder, anxiety disorder, delusional disorder and unspecified psychosis (psychotic symptoms that don't align with a specific psychotic disorder or mental illness). The Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to the current season, his/her location, had fair memory recall and required a one (1) person assist for transfers, ambulating and positioning. The assessment identified Resident #1 displayed agitated behaviors and was a high fall risk. The Resident Care Plan dated 11/24/25 identified that Resident #1 was at risk for falls due to impaired balance Interventions included applying floor mats at the resident's bedside when the resident was in bed, keeping the bed in the lowest position when the resident was in bed, arranging for a psychiatry consultation, encouraging the resident to spend time at the nurse's station when out of bed to the wheelchair for closer observation, offering controlled sensory stimulation input via an activity mat, evaluating the effectiveness and side effects of psychotropic medications with the provider for possible decrease in dosage or elimination of medication, offering to toilet the resident every two (2) hours while awake and removing the walker, rearranging the bedroom furniture to include the nightstand, offering to get resident out of bed to the wheelchair at 6:00 AM for fall prevention, ensuring the call bell was within reach when in the bed or the bedside chair, ensuring the environment was free of clutter, offering to play R&B music softly as needed to help calm the resident, providing a well-lit and clutter-free environment, physical and occupational therapies to help increase strength and endurance and therapy to evaluate wheelchair positioning. The nurse's note dated 11/21/25 at 10:54 PM identified at approximately 8:00 PM Resident #1 got out of bed without assistance and fell on the floor striking his/her face and head, sustaining two (2) lacerations (a cut/tearing of soft body tissue) above the left eyebrow. The note indicated the charge nurse, Licensed Practical Nurse (LPN) #1, notified the nursing supervisor, Registered Nurse (RN) #1, and Advanced Practice Registered Nurse (APRN) and Resident #1 was transferred to the Emergency Department (ED) for evaluation. Upon further review, the nurse's notes failed to identify Resident #1 was assessed by the nursing supervisor, RN #1, following the fall on 11/21/25. The Situation, Background, Assessment, Recommendation (SBAR) dated 11/21/25 was noted to be completed by LPN #1 and did not include range of motion. The nurse's note dated 11/23/25 at 12:25 PM identified the nursing supervisor, RN #3, was notified of Resident #1's fall in the resident television lounge and upon arrival, Resident #1 was observed sitting in the wheelchair and the charge nurse, Licensed Practical Nurse (LPN) #2, informed him Resident #1 had independently transferred from the floor to the wheelchair. Resident #1 was noted with a laceration on his/her right lateral (closer to the side) eye, no bleeding was noted and the charge nurse reported she cleaned up the blood prior to his arrival. The note identified Resident #1 was assessed at that time and was noted to move all extremities (limbs) without any issue, the family and APRN were notified and Resident #1 was sent to the ED for further evaluation and to rule out any head injuries. The nurse's note dated 11/23/25 at 12:40 PM written by the charge nurse, LPN #2, identified Resident #1 was found on the floor after attempting to transfer from the wheelchair (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and was positioned on his/her right side and the nursing supervisor was notified. The note did not reflect documentation that Resident #1 had independently transferred from the floor to the wheelchair. Interview with LPN #2 on 1/7/26 at 10:27 AM identified on 11/23/25 she found Resident #1 on the floor bleeding, she panicked and although she should have called the nursing supervisor, RN #3, immediately to assess Resident #1, she did not and instead requested a nurse aide, Nurse Aide (NA) #1, help her get Resident #1 off the floor and into the wheelchair, which they did, and then she cleansed the laceration to the right side Resident #1's head. LPN #2 identified she then called RN #3 to assess Resident #1, and RN #3 educated her that she should not have gotten Resident #1 up off the floor prior to an RN assessment to ensure Resident #1 did not have significant injuries. The nurse's note dated 12/3/25 at 8:00 AM identified at approximately 7:45 AM Resident #1 was found lying on his/her left side on the floor in his/her room, minimal swelling was observed to the left temporal (the temple on the side of the head) region and no bleeding was noted. The note indicated the nursing supervisor, APRN and family were notified and neurological checks were initiated per protocol. Upon further review, the nurse's note failed to reflect documentation Resident #1 was assessed by a Registered Nurse following the 12/3/25 fall. The Situation, Background, Assessment, Recommendation (SBAR) dated 12/3/25 was noted to be completed by the charge nurse, LPN #3 and did not include range of motion. The nurse's note dated 12/22/25 at 7:36 PM identified Resident #1 was observed by the charge nurse to be sliding backwards out of the wheelchair to the floor and she was unable to catch Resident #1 in time, Resident #1 may have hit the back of their head, neurological signs were initiated, Resident #1 denied any pain or discomfort and no injuries or swelling were observed. The note indicated the nursing supervisor, RN #5, was notified and arrived immediately for assessment, the nursing supervisor's note was to follow, and Resident #1 was being transferred to the ED for evaluation. Upon further review, the nurse's notes failed to identify the nursing supervisor's note documenting Resident #1's assessment following the fall on 12/22/25. An incomplete Situation, Background, Assessment, Recommendation (SBAR) dated 12/22/25 was noted to be completed by RN #5 and did not include range of motion. Interview with RN #5 on 1/7/26 at 10:11 AM identified she did respond and assess Resident #1 immediately following the fall on 12/22/25 and she did not assess range of motion, stating her concern was Resident #1's head after the head strike to the floor, Resident #1 denied any pain, and she should have done a full assessment regardless. RN #5 identified she was unaware the SBAR was not completed, and she should have written a nurse's note of the incident and her assessment. Interview with the Director of Nursing (DON) on 1/7/26 at 12:10 PM identified that a full RN assessment was required to be completed on all residents after each fall and she was unaware full RN assessments had not been completed on Resident #1 after the falls on 11/21/25, 12/3/25 and 12/22/25. The DON identified RN assessments are required to be completed post fall prior to staff moving the resident, and on 11/23/25 LPN #2 should not have assisted Resident #1 to the wheelchair prior to the nursing supervisor assessing Resident #1. Although attempted, an interview with RN #1, RN #3, and RN #8 were not obtained. Review of the Fall policy (undated) directed, in part, that the facility will maintain a proactive fall prevention program with interdisciplinary collaboration and all fall events will be documented, investigated and used to inform care planning. Post-fall assessments will be conducted by an RN and all falls will be reviewed to determine cause and inform ongoing prevention strategies. An RN will assess the resident immediately following any fall. Transfer from the floor will only occur once an RN has completed the assessment and deemed it appropriate. All falls will be reviewed regularly in facility at-risk meetings to identify trends or recurring risk factors.

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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 clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Residents #1) who were reviewed for falls, the facility failed to ensure the resident was properly positioned in the tilt-in-space wheelchair and was not tilted back greater than forty-five (45) degrees which resulted in the resident getting out of the wheelchair unassisted and falling. The findings include:Resident #1's diagnoses included catatonic disorder (a neuropsychiatric disorder that presents with abnormal motor, behavioral, and emotional responses which can include immobility, excessive movement and unusual postures or speech), major depressive disorder, anxiety disorder, delusional disorder and unspecified psychosis (psychotic symptoms that don't align with a specific psychotic disorder or mental illness). The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) indicating Resident #1 had some memory recall deficits, required staff assistance with activities of daily living required substantial assistance for bed mobility and was dependent on staff for transfers. The Resident Care Plan dated 12/18/25 identified that Resident #1 was at risk for falls due to impaired balance. Interventions included to encourage the resident to spend time at the nurse's station when out of bed in the wheelchair for closer observation, offer to toilet the resident every two (2) hours while awake, remove the walker and Physical Therapy (PT)/Occupational Therapy (OT) to help increase strength and endurance. The nurse's note dated 12/21/25 at 9:08 AM identified at approximately 8:00 AM the nursing supervisor, Registered Nurse (RN) #4, was called to the unit with reports of Resident #1 having a fall. The note indicated Resident #1 was found in the dining room lying on his/her right side and had sustained a two (2) centimeter (cm) laceration (a cut/tearing of soft body tissue) to the right eyebrow with a small amount of bloody drainage noted. The note identified pressure was applied to the area, Resident #1 denied any pain, was assessed and no further injuries were noted. The note identified Resident #1 was assisted by two (2) staff back into the wheelchair, the family, Director of Nursing (DON) and provider were notified of the incident, and an order was obtained to transfer Resident #1 to the Emergency Department (ED) for evaluation. Interview with RN #4 and the charge nurse, Licensed Practical Nurse (LPN) #2, on 1/7/26 at 9:03 AM identified when they responded to the fall, Resident #1's wheelchair was reclined back so Resident #1 was lying flat to prevent him/her from climbing out, however Resident #1 had subsequently climbed out and was found on the floor. They were not sure who had reclined the wheelchair back and reported that the wheelchair should not have been. Interview with a nurse aide, Nurse Aide (NA) #4, on 1/7/26 at 2:28 PM identified she was unable to recall any details leading up to the fall or the fall itself and was unable to recall why Resident #1 was reclined back in the wheelchair. The nurse's note dated 12/22/25 at 7:36 PM identified Resident #1 was observed by the charge nurse to be sliding backwards out of his/her wheelchair to the floor and she was unable to catch Resident #1 in time and reported Resident #1 may have hit the back of their head. The note identified the nursing supervisor, RN #5, was notified, arrived immediately for assessment, and Resident #1 was transferred to the ED for evaluation. Review of the facility Accident and Investigation paperwork for the 12/22/25 fall identified an intervention, in part, for a PT/OT consultation for an alternative wheelchair. Interview with LPN #4 on 1/7/26 at 9:09 AM identified on 12/22/25 Resident #1 was reclined back to an almost lying position in a tall back custom wheelchair at the nurse's station. LPN #4 stated she started to administer medications to another resident about ten (10) feet away when Resident #1's wheelchair tipped backwards, and Resident #1 slid backwards out over the headrest at the top of the wheelchair, she was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to get to Resident #1 in time. LPN #4 identified Resident #1 had a history of leaning and lunging forward while in the wheelchair, so they would often recline the wheelchair back to prevent Resident #1 from getting out of the wheelchair, to help the resident rest, and safety as staff were unable to always watch Resident #1. Interview with RN #5 on 1/7/26 at 10:11 AM identified although she did not witness the fall, she had observed staff reclining Resident #1 back in the wheelchair in the past to prevent Resident #1 from climbing out of the wheelchair. Interview with the Rehab Director, Occupational Therapist (OT) #1, on 1/7/25 at 11:36 AM identified following the 12/21/25 fall, therapy was not notified the the fall was out of the wheelchair or there were any issues with the wheelchair, a screen was not requested for wheelchair positioning or an alternative wheelchair. OT #1 stated following Resident #1's fall from the wheelchair on 12/22/25, therapy evaluated the wheelchair immediately the morning of 12/23/25 and identified the tilt stop was broken and staff were able to fully recline Resident #1 in the wheelchair when the stop should have prevented the wheelchair from tilting back farther than forty-five (45) degrees. OT #1 explained maintenance repaired the chair immediately on 12/23/25 and identified therapy would subsequently be ensuring all facility owned wheelchairs were functioning appropriately before being given to residents for use. OT #1 identified staff should have never utilize the reclining function on the wheelchair to keep Resident #1 in the wheelchair, reporting that it was dangerous for Resident #1 to fall out of the wheelchair when it was reclined versus when it was upright and was not safe to be reclined back further than 45 degrees. Interview with the Director of Nursing (DON) on 1/7/25 at 12:10 PM identified she was unaware the staff had reclined Resident #1 back in the wheelchair prior to both the 12/21/25 and 12/22/25 falls. The DON identified if staff were having difficulties with positioning Resident #1 in the wheelchair, they should have notified therapy immediately for intervention. Review of the Fall policy (undated) directed, in part, that post-fall assessments will be conducted by an RN and all falls will be reviewed to determine cause and inform ongoing prevention strategies. The facility will maintain a proactive fall prevention program with interdisciplinary collaboration and all fall events will be documented, investigated and used to inform care planning. All falls will be reviewed regularly in facility at-risk meetings to identify trends or recurring risk factors. Although requested, a policy on wheelchair positioning was not obtained.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for the use of anti-psychotic medication, the facility failed to ensure targeted behavior monitoring was put into place upon the initiation of an anti-psychotic medication. The findings include:Resident #1's diagnoses included catatonic disorder (a neuropsychiatric disorder that presents with abnormal motor, behavioral, and emotional responses which can include immobility, excessive movement and unusual postures or speech), major depressive disorder, anxiety disorder, delusional disorder and unspecified psychosis (psychotic symptoms that don't align with a specific psychotic disorder or mental illness). The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) indicating Resident #1 had some memory recall deficits and received antianxiety and hypnotic medications. The psychiatric Advanced Practice Registered Nurse's (APRN) note dated 12/23/25 identified there were concerns Resident #1 may have undiagnosed bipolar disorder, depression, or significant trauma history as medical causes for catatonia were ruled out. The note directed that she would trial Abilify (an anti-psychotic medication) at a low dose, and she would be ordering Abilify 2 milligrams (mg) daily. A physician's order dated 12/23/25 directed to administer Abilify 2 mg tablet, give 2 mg bymouth one (1) time a day for delusional disorder (having false beliefs based on an incorrect interpretation of reality). Review of the December 2025 electronic Medication Administration Record (eMAR) failed to reflect documentation the targeted behaviors were monitored every shift related to the use of the Abilify. The psychiatric APRN note dated 1/2/26 identified Resident #1 continued to exhibit restlessness and yelling out and the plan was to increase the Abilify to 5 mg daily for psychosis and other behaviors of concern included avolition and impulsiveness. A physician's order dated 1/2/26 directed to administer Abilify 5 mg tablet, give 5 mg bymouth one (1) time a day for psychosis. Review of the January 2026 eMAR failed to reflect documentation the targeted behaviors were monitored every shift related to the use of the Abilify. Interview with the psychiatric APRN on 1/7/26 at 1:12 PM identified Resident #1 should have had behavior monitoring put into place upon the initiation of the Abilify on 12/23/25 to include the targeted behaviors of restlessness, impulsiveness, delusions, hallucinations and paranoia. Interview and clinical record review with both the Director of Nursing (DON) and Regional Nurse, Registered Nurse (RN) #7, on 1/7/26 at 12:10 PM identified targeted behavior monitoring should have been put into place for Resident #1 upon the initiation of the Abilify, and the Nursing Supervisors or Nursing Administration who confirmed the Abilify order should have also ensured an order for the targeted behavior monitoring was put into place. Review of the Behavior Monitoring/Antipsychotic Medications policy dated 06/2019 directed, in part, that residents receiving anti-psychotic medications will have specific target behaviors identified and monitored every shift. Any time a resident is started on an antipsychotic medication a behavior flow sheet will be initiated.