STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075089	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Middletown	600 Highland Ave 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 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 review, facility documentation review, facility policy review, and interviews for three of four residents (Resident #2, #3 and #6) reviewed for medication errors, the facility failed to ensure the physician/APRN was notified timely when medications were not administered timely in accordance with physician orders. The findings include: Resident #2's diagnoses included diabetes and depression. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment. The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 had diabetes, risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and risk for seasonal allergies. Interventions directed to administer meds as ordered and check blood sugar via fingerstick as ordered. Physician orders dated 3/25/2026 directed the following:fingerstick for blood sugar level four (4) times a day for diabetesKlor-Con 10 Oral Tablet Extended Release 10 MEQ (milliequivalent) give three (3) tablets by mouth one time a day for hypokalemia (low potassium)Guaifenesin Oral Tablet 400 mg give one (1) tablet by mouth two (2) times per day for congestion. Physician order dated 4/13/2026 directed Insulin Lispro Injection Solution 100 unit/ml (milliliter) inject 6 units subcutaneously with meals for diabetes. Review of MAR dated 4/15/2026 identified the medications were scheduled to be administered at 8 AM, and Resident #2 did not receive the above listed medications. Additional review identified the flowing:The finger stick was signed and coded as #2 to indicated refused.Klor-Con 10 Oral was signed/coded as 12 (medication unavailable).Guaifenesin Oral Tablet was signed/coded as 12 (medication unavailable).Insulin Lispro 6 units was signed/coded as 3 to identify the medication was held and see nursing notes. Review of the nursing note dated 4/15/2026 failed to identify the fingerstick was not obtained and/or refused, and failed to identify the Klor-Con, Guaifenesin and Lispro insulin were not administered as ordered. Interview and record review with the DNS on 5/13/2026 at 11:17 identified Resident #2 was followed by APRN #2. Although the DNS stated she had notified APRN that some of the medications were not administered, however she was unable to provide documentation that APRN #2 was notified the finger stick was obtained, the Lispro insulin, Klor-Con 10 Oral and Guaifenesin were administered as ordered. Interview on 5/12/2026 at 11:20 AM APRN #2 identified she was not notified of the missed medications. Interview on 5/12/2026 at 11:43 AM interview with APRN #3 identified she was covering for APRN #2 on 4/4/15/2026 and she was not notified of the missed medications, and if they were not administered, or the resident refused, she would have wanted to be notified. APRN #3 stated she should have been notified especially since Resident #2's blood sugar was elevated at 12 noon (313) and she was concerned that the Klor-Con was missed. 2. Resident #3's diagnoses included diabetes, dementia and schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS score of seven out of ten, indicative of moderate cognitive impairment. The RCP dated 4/9/2026 identified Resident #3 had diabetes, was at was at risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and potential for alteration in mood. Intervetnions directed to administer meds as ordered and, check blood sugar via fingerstick as ordered. Physician orders dated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8/2026 directed to administer the following at 8 AM:fingerstick for blood glucose level two (2) times a day for diabetesInsulin Lispro Injection Solution, inject six (6) units subcutaneously with meals for diabetes for diabetes,Aripiprazole (Abilify) Oral Tablet 10 mg, give 10 mg by mouth one (1) time a day for schizophreniaLiquid Protein two (2) times a day 30 milliliters (ml) liquid protein. Review of the electronic MAR notes identified the fingerstick, Lispro insulin, and liquid protein were coded at 12:42 PM as #3 that indicated hold, see nursing notes; Abilify was coded at 12:42 PM as #12 medication unavailable. Review of nursing notes dated 4/15/2026 failed to identify the physician/APRN was notified that fingerstick, insulin and medications that were not administered as ordered. On 5/13/2026 at 11:17 AM interview and record review with DNS identified RN #1 should have notified APRN #1. Although the DNS stated she notified APRN #1 the medications were not administered and the fingerstick was not obtained, she was unable to provide documentation the APRN was notified. On 512/2026 at 11:21 AM interview with APRN #1 identified that she was not notified the medications were not administered and the fingerstick was not obtained, and stated she would have wanted to be notified. 3. Resident #6's diagnoses included non-pressure chronic ulcer of right lower leg, cellulitis and chronic pain. The quarterly MDS assessment dated [DATE] identified Resident #6 had a BIMS score of twelve out of fifteen, indicative of no cognitive impairment. The RCP dated 3/11/2026 identified Resident #6 had cellulitis, interventions directed pain management as ordered. Physician orders dated 3/25/2026 directed Xtampza ER Oral Capsule (extended-release capsule containing oxycodone for pain) 12-hour abuse-deterrent 9 mg, give one (1) capsule by mouth every 12 hours related to other chronic pain. Additional order directed Oxycodone HCL 5 mg every four (4) hours as needed for pain. Review of Medication Administration Report dated 4/15/2026 identified Resident #6 did not receive the 9 AM Xtampza ER 9 mg scheduled at 9 AM, and it was signed with a code #2 to indicate the medication was refused. Review of nursing progress note dated 4/15/2026 failed to identify the physician/APRN was notified the Xtampza was not administered as ordered. Interview and record review on 5/7/2026 at 11:24 AM with RN #1 identified she did not administer the Xtampza, and she did not notify the DNS, ADNS or the APRN. Interview and record review with RN #3 on 5/12/2026 at 9:20 AM identified she was the supervisor on 4/15/2026 and she was working on a unit passing morning medications for residents on her unit. RN #3 stated she did not recall that RN #1 was late that day, and she was not aware medications were administered late or omitted. On 5/13/2026 at 11:17 AM interview and record review with DNS identified Resident #6 had no history of medication refusals, and the medication was coded as refused on 4/15/2026. The DNS stated the physician/APRN should have been notified. The DNS further stated she thought she may have notified the APRN and if she did she would have written a nursing note, but was unable to provide documentation that she had notified the ARPN. Interview on 5/12/2026 at 11:20 AM APRN #2 indicated she was not working on 4/15/2026 (she was not notified the Xtampza was not given) and APRN #3 was covering. Interview on 5/12/2026 at 11:43 AM interview with APRN #3 identified she was not notified by the nurse or the DNS that the Xtampza was not administered as ordered, and stated she would want to have been notified. Subsequent to surveyor inquiry the DNS wrote a nursing note dated 5/7/2026 that identified on 4/15/2026 medication administration was delayed and APRN #2 was updated. Interview and record review on 5/7/2026 at 11:24 AM with RN #1 identified she did not administer the medications listed above for Residents #2, #3 and #6 and she did not notify the DNS, the ADNS, the physician or any APRN. Interview failed to identify why she did not notify. Interview and record review with MD #1 on 5/12/2026 at 12:16 PM with MD #1 identified he was not notified on 4/15/2026 that the medications were not administered as ordered for Residents #2, #3 and #6. MD #1 stated he was notified by the DNS last week (the week of 5/4/2026) that the medications were not administered as ordered. Review of facility Medication Administration policy directed in part; to administer medications one (1) hour before or after the ordered time. Review of facility Change in Condition/Family/MD Notification Policy directed in part; to make resident's physician and family aware of any significant change in condition, all significant changes in residents' condition will be (continued on next page)

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Apple Rehab Middletown	600 Highland Ave 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to physician and family, the nurse will document in the nurse's notes that the physician and family or responsible party have been notified of a change in condition.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for four of four residents (Resident #1, #2, #3 and #6) reviewed for medication errors, the facility failed to ensure licensed staff covered a unit to administer medications timely and failed to ensure the residents were free from neglect when medications were not administered timely in accordance with physician orders and facility policy. The findings include: Resident #1's diagnoses included diabetes, arthritis, atrial fibrillation and morbid obesity. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen, indicative of no cognitive impairment, required assistance with ADLs (activities of daily living), and received anticoagulant (medication to prevent blood clots, diuretics, and hypoglycemic medication (to control blood sugar). The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 had diabetes, a risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and pain risk. Interventions directed to administer medications as ordered, and assess pain. Physician orders dated 4/16/2026 directed to administer the following:Jardiance Oral Tablet (used to control blood sugar) 25 milligrams (mg) give one (1) tablet by mouth one (1) time a day for diabetes type 2.Vitamin D3 Tablet 4000 units by mouth once a day for supplement.Ammonium Lactate External Cream 12 % (moisturizer), apple to bilateral thighs topically two (2) times a day. Review of April MAR dated 4/15/2026 identified Resident #1's fingerstick on 4/15/2026 at 9 AM was 227. Review of Medication Administration Record (MAR) dated 4/15/2026 identified the following medications were scheduled to be administered at 9 AM and were not signed to indicate they were administered at 9 AM: Jardiance Oral Tablet (used to control blood sugar) 25 milligrams (mg) give one (1) tablet by mouth one (1) time a day for diabetes type 2.Vitamin D3 Tablet 4000 units by mouth once a day for supplement.Ammonium Lactate External Cream 12 % (moisturizer), apple to bilateral thighs topically two (2) times a day. Review of the electronic MAR notes identified the Jardiance was signed with a code 12 at 1:11 PM, the Vitamin D was coded at 1:12 PM with a #12, and the Ammonium Lactate was coded at 1:04 PM, and were all signed/coded as #12. Additional review identified a code 12 indicated the medication was unavailable. 2. Resident #2's diagnoses included diabetes and depression. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment. The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 had diabetes, risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and risk for seasonal allergies. Interventions directed to administer meds as ordered and check blood sugar via fingerstick as ordered. Physician orders dated 3/25/2026 directed the following:fingerstick for blood sugar level four (4) times a day for diabetes.Klor-Con 10 Oral Tablet Extended Release 10 MEQ (milliequivalent) give three (3) tablets by mouth one time a day for hypokalemia (low potassium).Guaifenesin Oral Tablet 400 mg give one (1) tablet by mouth two (2) times per day for congestion. Physician order dated 4/13/2026 directed Insulin Lispro Injection Solution 100 unit/ml (milliliter) inject 6 units subcutaneously with meals for diabetes. Review of the MAR dated 4/15/2026 identified the medications were scheduled to be administered at 9 AM, and Resident #2 did not receive the above listed medications. Additional review identified the following:The finger stick was signed and coded as #2 to indicated refused.Klor-Con 10 Oral was signed/coded as 12 (medication unavailable).Guaifenesin Oral Tablet was signed/coded as 12 (medication unavailable).Insulin Lispro 6 units was signed/coded as 3 to identify the medication was held and see nursing notes. Review of the nursing note dated 4/15/2026 failed to identify the fingerstick was not obtained and/or refused, and failed to identify the Klor-Con, Guaifenesin and Lispro insulin were not administered as ordered. 3. Resident #3's diagnoses included diabetes, dementia and schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #3 had (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a BIMS score of seven out of ten, indicative of moderate cognitive impairment. The RCP dated 4/9/2026 identified Resident #3 had diabetes, was at was at risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and potential for alteration in mood. Interventions directed to administer meds as ordered and, check blood sugar via fingerstick as ordered. Physician orders dated 4/8/2026 directed to administer the following at 8 AM:fingerstick for blood glucose level two (2) times a day for diabetesInsulin Lispro Injection Solution, inject six (6) units subcutaneously with meals for diabetes for diabetes,Aripiprazole (Abilify) Oral Tablet 10 mg, give 10 mg by mouth one (1) time a day for schizophreniaLiquid Protein two (2) times a day 30 milliliters (ml) liquid protein. Review of the electronic MAR notes identified the fingerstick, Lispro insulin, and liquid protein were coded at 12:42 PM as #3 that indicated hold, see nursing notes; Abilify was coded at 12:42 PM as #12 medication unavailable. 4. Resident #6's diagnoses included non-pressure chronic ulcer of right lower leg, cellulitis and chronic pain. The quarterly MDS assessment dated [DATE] identified Resident #6 had a BIMS score of twelve out of fifteen, indicative of no cognitive impairment. The RCP dated 3/11/2026 identified Resident #6 had cellulitis, interventions directed pain management as ordered. Physician orders dated 3/25/2026 directed Xtampza ER Oral Capsule (extended-release capsule containing oxycodone for pain) 12-hour abuse-deterrent 9 mg, give one (1) capsule by mouth every 12 hours related to other chronic pain. Additional order directed Oxycodone HCL 5 mg every four (4) hours as needed for pain. Review of Medication Administration Report dated 4/15/2026 identified Resident #6 did not receive the 9 AM Xtampza ER 9 mg scheduled at 9 AM, and it was signed with a code #2 to indicate the medication was refused. Interview and record review on 5/7/2026 at 11:24 AM with RN #1 identified she did not administer the Xtampza, and she did not notify the DNS, ADNS or nursing supervisor. Interview and record review with RN #3 on 5/12/2026 at 9:20 AM identified she was the supervisor on 4/15/2026 and she was working on a unit passing morning medications for residents on her unit. RN #3 stated she did not recall that RN #1 was late that day, and she was not aware medications were administered late or omitted. Interview and record review with RN #1 on 5/7/2026 at 11:24 AM identified she was the charge nurse on the 7 AM to 3 PM shift on 4/15/2026. RN #1 stated she had only worked at the facility for about one (1) month and worked the evening shift (3 to 11 PM) on a different unit. She was working in different facility during the night shift, ending at 7 AM on 4/15/2026 and when this facility asked her to work the 7 AM to 3 PM she had advised the facility that while she could work for them, she would be arriving about 9 AM due to the time required for travel from the other location to this facility, and the DNS and ADNS were both aware that she would be arriving late for her shift. RN #1 stated she was told the medication pass would be started prior to her arrival. When she arrived, she received help from another charge nurse to complete blood sugar testing upon arrival and administered insulin. RN #1 stated she documented held medications/orders on the MAR, did not administer breakfast insulin if it was missed but gave the lunch dose of insulin, and she documented Resident #1's unavailable medications on the MAR but did not write a nursing note. RN #1 stated she did not check the automated medication machine (emergency medication supply) for missing medications because she was behind on her medication pass, and informed the next shift at 3 PM of medications that were not administered. RN #1 did not notify the DNS or ADNS. RN #1 stated she should have asked for help to ensure medications were administered timely. On 5/13/2026 at 11:17 AM interview and record review with the DNS identified RN #1 was scheduled to work as the charge nurse on 4/15/2026, and she was aware RN #1 was not in the building at the start of the shift, and stated she could not have been passing medications to residents. The DNS stated she was enroute to the facility when she was notified RN #1 was going to be late and she did not assign another nurse to start the medication pass, do fingersticks or administer insulin. Although the DNS stated RN #1 punched in at 9:06 AM, the DNS failed to identify how the facility supported RN #1's medication pass after her late arrival, and failed to identify how the facility ensured fingersticks were obtained and medications and insulin were administered timely when the facility was aware RN #1 was arriving late. Interview failed to identify the facility had a plan (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to manage staffing to ensure resident medications were administered timely when the nurse was expected to be one (1) and a half hours late to start the shift and medication pass. Facility documentation review identified RN #1 punched into work on 4/15/2026 at 9:06 AM (one hour and a 36 minutes after the shift started). Review of facility Abuse Policy directed in part, neglect was the failure to provide goods or services necessary for physical, mental or psychosocial well-being.

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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 review, facility documentation review, facility policy review, and interviews for four of four residents (Resident #1, #2, #3 and #6) reviewed for medication errors, the facility failed to ensure medications were administered timely and failed to ensure staff searched for medications that were unavailable in the unit medication cart. The findings include: Resident #1's diagnoses included diabetes, arthritis, atrial fibrillation and morbid obesity. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen, indicative of no cognitive impairment, required assistance with ADLs (activities of daily living), and received an anticoagulant (medication to prevent blood clots), diuretics, and hypoglycemic medication (to control blood sugar). The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 had diabetes, a risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and pain risk. Interventions directed to administer medications as ordered, and assess pain. Physician orders dated 4/16/2026 directed to administer the following:Jardiance Oral Tablet (used to control blood sugar) 25 milligrams (mg) give one (1) tablet by mouth one (1) time a day for diabetes type 2.Vitamin D3 Tablet 4000 units by mouth once a day for supplement.Ammonium Lactate External Cream 12 % (moisturizer), apple to bilateral thighs topically two (2) times a day. Review of April MAR dated 4/15/2026 identified Resident #1's fingerstick on 4/15/2026 at 9 AM was 227. Review of Medication Administration Record (MAR) dated 4/15/2026 identified the following medications were scheduled to be administered at 9 AM and were not signed to indicate they were administered at 9 AM:Jardiance Oral Tablet (used to control blood sugar) 25 milligrams (mg) give one (1) tablet by mouth one (1) time a day for diabetes type 2.Vitamin D3 Tablet 4000 units by mouth once a day for supplement.Ammonium Lactate External Cream 12 % (moisturizer), apple to bilateral thighs topically two (2) times a day. Review of the electronic MAR notes identified the Jardiance was signed with a code 12 at 1:11 PM, the Vitamin D was coded at 1:12 PM with a #12, and the Ammonium Lactate was coded at 1:04 PM, and were all signed/coded as #12. Additional review identified code 12 indicated the medication was unavailable. 2. Resident #2's diagnoses included diabetes and depression. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment. The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 had diabetes, risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and risk for seasonal allergies. Interventions directed to administer meds as ordered and check blood sugar via fingerstick as ordered. Physician orders dated 3/25/2026 directed the following:fingerstick for blood sugar level four (4) times a day for diabetes.Klor-Con 10 Oral Tablet Extended Release 10 MEQ (milliequivalent) give three (3) tablets by mouth one time a day for hypokalemia (low potassium).Guaifenesin Oral Tablet 400 mg give one (1) tablet by mouth two (2) times per day for congestion. Physician order dated 4/13/2026 directed Insulin Lispro Injection Solution 100 unit/ml (milliliter) inject 6 units subcutaneously with meals for diabetes. Review of the MAR dated 4/15/2026 identified the medications were scheduled to be administered at 9 AM, and Resident #2 did not receive the above listed medications. Additional review identified the following:The finger stick was signed and coded as #2 to indicated refused.Klor-Con 10 Oral was signed/coded as 12 (medication unavailable).Guaifenesin Oral Tablet was signed/coded as 12 (medication unavailable).Insulin Lispro 6 units was signed/coded as 3 to identify the medication was held and see nursing notes. 3. Resident #3's diagnoses included diabetes, dementia and schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS score of seven out of ten, indicative of moderate cognitive impairment. The RCP dated 4/9/2026 identified Resident #3 had diabetes, was at was at risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and potential for alteration in mood. Interventions directed to administer meds as ordered and, check blood sugar via fingerstick (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as ordered. Physician orders dated 4/8/2026 directed to administer the following at 8 AM:fingerstick for blood glucose level two (2) times a day for diabetesInsulin Lispro Injection Solution, inject six (6) units subcutaneously with meals for diabetes for diabetes,Aripiprazole (Abilify) Oral Tablet 10 mg, give 10 mg by mouth one (1) time a day for schizophreniaLiquid Protein two (2) times a day 30 milliliters (ml) liquid protein. Review of the electronic MAR notes identified the fingerstick, Lispro insulin, and liquid protein were coded at 12:42 PM as #3 that indicated hold, see nursing notes; Abilify was coded at 12:42 PM as #12 medication unavailable. 4. Resident #6's diagnoses included non-pressure chronic ulcer of right lower leg, cellulitis and chronic pain. The quarterly MDS assessment dated [DATE] identified Resident #6 had a BIMS score of twelve out of fifteen, indicative of no cognitive impairment. The RCP dated 3/11/2026 identified Resident #6 had cellulitis, interventions directed pain management as ordered. Physician orders dated 3/25/2026 directed Xtampza ER Oral Capsule (extended-release capsule containing oxycodone for pain) 12-hour abuse-deterrent 9 mg, give one (1) capsule by mouth every 12 hours related to other chronic pain. Additional order directed Oxycodone HCL 5 mg every four (4) hours as needed for pain. Review of Medication Administration Report dated 4/15/2026 identified Resident #6 did not receive the 9 AM Xtampza ER 9 mg scheduled at 9 AM, and it was signed with a code #2 to indicate the medication was refused. Interview and record review on 5/7/2026 at 11:24 AM with RN #1 identified she did not administer the Xtampza on 4/15/2026, and she did not notify the DNS, ADNS or nursing supervisor. Interview failed to identify why the Xtampza was not administered and why the MAR was signed with a code 2 to indicate the medication was refused. Interview and record review with RN #3 on 5/12/2026 at 9:20 AM identified she was the supervisor on 4/15/2026 and she was working on a unit passing morning medications for residents on her unit. RN #3 stated she did not recall that RN #1 was late that day, and she was not aware medications were administered late or omitted. RN #3 stated RN #1 notified her when RN #1 arrived in the facility and she was not initially concerned about medication administration timing as she believed it remained within the medication pass window of one (1) hour before or after the scheduled time. Interview failed to identify they time RN #1 arrived. RN #3 stated she was aware RN #1 usually worked the 3 to 11 PM shift and that the unit assigned had heavier care needs. RN #3 stated if she had known RN #1 would arrive at 9 AM, she would have completed the unit's fingersticks and insulin administrations before RN #1 arrived. Interview and record review with RN #1 on 5/7/2026 at 11:24 AM identified she was the charge nurse on the 7 AM to 3 PM shift on 4/15/2026. RN #1 stated she had only worked at the facility for about one (1) month and worked the evening shift (3 to 11 PM) on a different unit. She was working in different facility during the night shift, ending at 7 AM on 4/15/2026 and when this facility asked her to work the 7 AM to 3 PM she had advised the facility that while she could work for them, she would be arriving about 9 AM due to the time required for travel from the other location to this facility, and the DNS and ADNS were both aware that she would be arriving late for her shift. RN #1 stated she was told the medication pass would be started prior to her arrival. When she arrived, she received help from another charge nurse to complete blood sugar testing upon arrival and administered insulin. RN #1 stated she documented held medications/orders on the MAR, did not administer breakfast insulin if it was missed, but gave the lunch dose of insulin, and she documented Resident #1's unavailable medications on the MAR. RN #1 stated she did not search the medication room for additional supplies of medications, she did not check the automated medication machine (emergency medication supply) for missing medications and she did not contact the supervisor or DON to obtain additional medication supplies because she was behind on her medication pass. RN #1 stated she informed the next shift at 3 PM of medications that were not administered. RN #1 did not notify the DNS or ADNS. RN #1 stated she should have asked for help to ensure medications were administered timely. Facility documentation review identified RN #1 punched into work on 4/15/2026 at 9:06 AM (one hour and a 36 minutes after the shift started). Additional attempts to interview RN #1 during the survey regarding Resident #2, #3 and 6's medication administration on 4/15/2026 were unsuccessful. Interview and record review with the DNS on (continued on next page)

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	075089	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Middletown	600 Highland Ave Middletown, CT 06457

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/13/2026 at 11:17 AM identified RN #1 was scheduled to work as the charge nurse on 4/15/2026, and she was aware RN #1 was not in the building at the start of the shift, and could not have been passing medications to residents. The DNS stated she was enroute to the facility when she was notified RN #1 was going to be late and she did not assign another nurse to start the medication pass, do fingersticks or administer insulin. Although the DNS stated RN #1 punched in at 9:06 AM, the DNS stated she did not assign another nurse to the unit at 7:30 AM to begin the medication pass to ensure resident medications were administered timely. Although the DNS stated during the shift she asked RN #1 how things were going she did not identify medications were not administered timely and was not aware prior to surveyor inquiry. The DNS stated the fingersticks, insulin and medications that were not administered should have been administered by another nurse assigned to cover when RN #1 was identified to be arriving late for her shift. Review of facility Medication Administration policy directed in part, that all medications will be administered in accordance with physician orders, one (1) hour before or after the scheduled time.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for activities of daily living, the facility failed to ensure staff acted timely on therapy recommendations for alternative lifts for transfers. The findings include: Resident #1's diagnoses included arthritis, abnormal posture and morbid obesity. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen, indicative of no cognitive impairment, required assistance with ADLs (activities of daily living). The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 required assistance with ADLs. Interventions directed to assist with ADLs and transfers as indicated, physical therapy and occupational therapy as ordered, and offer out of bed Monday, Wednesday and Friday after breakfast and back to bed before end of first shift. Observation and interview on 5/7/2026 at 9:54 AM with Resident #1 identified he/she had a collapsible oversized wheelchair in his/her room and got out of bed to the wheelchair on Mondays, Wednesdays, and Fridays, with assistance of two (2) aides and a mechanical lift. Resident #1 stated he/she would like to get out of bed more often and could only tolerate sitting in the wheelchair for limited periods due to discomfort on his/her bottom and back, and Resident #1 was willing to get up to a recliner chair. Resident #1 further identified the facility had attempted to obtain a wheelchair that he/she could exit the room with, however, he/she was told it was too wide for the doorway. Observation and interview on 5/12/2026 at 2:05 PM with Resident #1 while Resident #1 was in bed, he/she would like to get out of bed to a recliner, and he/she was currently getting up to a standard wheelchair. Resident #1 stated when in the (bariatric) wheelchair, he/she filled the wheelchair side-to-side. Review of a typed piece of paper provided by PT #1, labeled Occupational Therapy Screen dated 11/6/2025 with OT #'s name typed at the bottom of the page identified Reason: seating options: family request. The paper indicated an extensive investigation for optional out of bed seating options and inquiry for a customized wheelchair (CWC) was completed in the past. Pursuit of CWC in the past, (Sept and [DATE]) with vendors unable to make a chair to the resident's specification and needs. Pursuit of the facility bariatric power recliner chair (reference documentation 6/5/2025) found chair incompatibility with facility mechanical lift as the lift does not fit around the recliner chair as recliner seat width is 29 inches and the chair base width is 36 inches. Resident #1 currently using a 28-inch-wide wheelchair seat width, but measurements taken today reveal his/her current seat width hips/buttocks is 34 inches. The facility mechanical lift will not go around the 36-inch seat width in order to position and place him/her in the power recliner chair. OT #1 contacted community CWC vendors to inquire about potential changes and new options. New wide CWCs can accommodate up to 600 lbs with the maximal seat base width of 30 inches and the overall chair width 42 inches due (to) requirements and safety anti-tippers, wheels, casters, wheel push rims, and arm rest supports. The chair is rigid and unable to be folded. Door with into room is 39 inches therefore the chair will not be able to fit thought the doorway. In addition, the facility mechanical lift will not fit around a CWC. Unfortunately this therapist has exhausted all seating options with the only recommendation to pursue potential options for alternative lifts. This information was communicated to the rehab director and will be communicated with the facility administrator and the interdisciplinary team which will include the director of nursing and the social worker. The team will decide how best to share this information with the resident and/or family who on 11/5/2025 was inquiring about a CWC. Interview on 5/12/2025 at 11:58 AM with PT #1 (Rehab Director) identified Resident #1 was evaluated on 3/13/2026 (61 days prior to interview) and therapy had recommended a bariatric recliner, however the facility's current mechanical lift could not accommodate the recliner. PT #1 stated the information was relayed to nursing and maintenance, as therapy does not place orders for the mechanical lifts. Interview and record review on 5/12/2026 at 1:12 PM with OT #1 identified in November 2025 the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	findings of the Occupational Therapy Screen were shared during morning report with the rehab director, the Administrator, social worker and the DNS. The team was informed the facility bariatric recliner would work for Resident #1, the DNS had NAs assess if the mechanical lift would work with the chair and it was determined the lift could not accommodate the bariatric chair. The decision was that the facility was going to see if the company had another lift that would work. OT #1 stated it was her understanding that the DNS and the interdisciplinary team, who were aware of the situation, would determine how and who would be responsible for obtaining a different lift that would fit the bariatric chair needed for Resident #1. Interview failed to identify why a mechanical lift was not obtained that would fit with the resident's chair since November 2025 (6 months prior). Interview with Corporate RN #4 on 5/12/2026 at 2:15 PM identified Resident #1's room had sufficient space to accommodate a large recliner and space to operate a mechanical lift that would accommodate Resident #1's needs. RN #4 was unable to explain why the facility had not pursued a mechanical lift that would work with the bariatric chair that the facility already had, that had been identified by therapy as an option for Resident #1. Interview failed to identify why a mechanical lift was not obtained that would fit with the resident's chair since November 2025 (6 months prior). Review of facility Resident Rights Policy directed in part, to provide quality care and services with reasonable accommodation of your individual needs and preferences.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, and interviews for one of three residents (Resident #1) reviewed for medication errors, the facility failed to ensure the physician orders were reviewed and renewed at least every 60 days. The findings included: Resident #1's diagnoses included diabetes, arthritis, atrial fibrillation and morbid obesity. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen, indicative of no cognitive impairment and required assistance with ADLs (activities of daily living). The Resident Care Plan (RCP) dated 3/13/2026 identified Resident #1 had diabetes, a risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar), and pain risk. Interventions directed to administer medications as ordered, and assess pain. Record review identified Resident #1 was on a 60-day schedule for review and renewal of physician orders. Record review failed to identify when the physician orders were last signed by the physician or APRN on either the paper record or the electronic medical record (EMR). Interview on 5/7/2026 at 2:10 PM with the DNS and Corporate RN #2 identified all resident physician orders should be signed every 30-days or every 60-days. Further, some resident orders were signed on paper, and some were electronic EMR orders. Interview identified all newly admitted resident orders are signed in the EMR, and any long-term resident orders that originated prior to the current EMR (example three (3) years ago) display in the EMR monthly report without any physician signatures and indicate the orders are signed as wet ink (indicated that means the physician/APRN sign on paper). The DNS and RN #2 were unable to provide any documentation that Resident #1's physician orders were reviewed and signed, and were unable to provide documentation as to the last time the orders were signed. In addition, the DNS and RN #2 were unable to provide any physician/APRN progress notes that indicated the monthly orders were reviewed and renewed. Subsequent to surveyor inquiry, Corporate RN #4 provided documentation that the monthly orders were signed by MD #1 on 4/16/2026, however RN #4 was unable to provide documentation of orders signed every sixty (60) days prior to 4/16/2026. RN #4 indicated the order should be signed at least every sixty (60) days. The facility did not provide a facility policy related to physician visit frequency, or physician order (paper or electronic) frequency of review and signatures.