STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Middletown		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observation, facility policy and interviews for 2 of 4 sampled residents (Resident #17 and Resident #52) reviewed for self-medication administration, the facility failed to ensure a medication self-administration assessment were completed according to policy for a resident receiving medication assisted therapy. The findings include: 1. Resident #17's diagnoses included opioids use and psychoactive substance abuse. The Self Administration of Medications assessment dated [DATE] identified Resident #17 wished to self-administer medications, was alert, oriented, able to name medication, dose, side effects, was physically able to open medications as packaged and drink water independently. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #17 as cognitively intact and independent with activities of daily living (ADL). The Resident Care Plan (RCP) dated 9/27/24 identified Resident #17 was at risk for potential side effects related to psychiatric drug use. Interventions included evaluating the effectiveness and side effects of medication and to consider decrease/elimination of the drug. An interview with Registered Nurse, RN #1 identified the Self Administration of Medications assessment was to be completed quarterly and was out of date. The assessment was updated after to surveyor inquiry. A review of the facility policy dated 10/30/2023 directed that the Self Administration of Medications assessment is completed on admission, quarterly, annually and when there is a significant change of condition. 2. Resident #52's diagnoses included Opioid Dependence, depression, and generalized anxiety disorder. The admission Minimum Data Set assessment dated [DATE] identified Resident #52 as cognitively intact and required maximum assistance with eating, oral hygiene, and was dependent for personal hygiene. The Resident Care Plan dated 1/15/24 identified Resident #52 was receiving methadone. Interventions included resident to self-administer methadone. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Self-Administration assessment dated [DATE] identified the resident was independent with opening medications as stored/packaged. The Self-Administration of Medications Assessment was completed on 5/16/24. The assessment indicated the resident was able to open medications as packaged A physician's order dated 10/1/24 identified Resident # 52 was on Methadone maintenance therapy for substance use disorder. In an interview with the Regional Director on 10/1/24 at 11:50 AM identified the Self-Administration of Medications Assessment are completed quarterly. After surveyor inquiry, the Self-Administration of Medications Assessment was completed on 10/1/24. The assessment indicated the resident was able to open medications as packaged. Observation and interview with RN# 3 on 10/2/24 at 8:30 AM identified RN #3 opened the methadone bottle for the resident. RN #3 stated the resident has a functional limitation and is unable to open the bottle. Review of the Methadone Maintenance policy dated 10/30/23 directed, in part, all residents on methadone maintenance therapy will have a self-administration assessment completed on admission, quarterly, and annually. 48792

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations, review of policy and staff interviews for 3 of 22 residents (Resident #20, 41, and #59) observed for call bell location within reach, the facility failed to ensure call bells were within reach of each resident. The findings included: 1. Resident #20's diagnosis included Parkinson's disease, dementia and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #20 as moderately cognitively Impaired. The Resident Care Plan (RCP) dated 7/23/2024 indicated Resident #20 could be impulsive Interventions included: to encourage the resident to call a staff member for assistance when needing to transfer, pick items off the floor and any other assistance. The care plan also indicated Resident #20 was at risk for falls with interventions including in part to encourage to the resident ask and wait for staff assistance for transfers and toileting. An observation and interview on 10/2/2024 at 2:50 PM identified Resident #20 sitting in a wheelchair next to the bed unable to find the call bell. Nurse Aide (NA)#7 was asked to come in and locate the call bell which she/he found wrapped around a lowered siderail near the head of the bed out of the resident's reach. NA 3 7 did not know why the call bell was not within the resident's reach. NA #7 untangled the call bell cord and moved the call bell button within reach of Resident#20's wheelchair. 2. Resident #41's diagnosis included polyarthritis, neuralgia, urge incontinence and irritable bowel syndrome. The quarterly MDS assessment dated [DATE] noted mildly cognitively impaired, dependent for transfer and toileting. The care plan dated 7/3/2024 indicated Resident #41 was at risk for falls. Interventions included in part to ensure the call bell was in reach when in bed or the bedside chair and to encourage to wait and ask for assistance for transfers and toileting. An observation and interview on 10/2/2024 at 3:05 PM identified Resident #41 unable to reach the call bell and, after informing RN #8(nursing supervisor) s/he was able to move the call bell from the side rail to where Resident #41 was could reach the bell. 3. Resident #59's diagnosis included fractures of the left humerus and left radius and ulna, and cognitive communication deficit. The quarterly MDS assessment dated [DATE] indicated Resident #59's cognitive status was severely impaired. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 6/23/2024 indicated Resident #59 was at risk for falls. Intervention includes: to ensure call bell was in reach when in bed or the bedside chair. An observation and interview on 10/2/2024 at 3:10 PM identified Resident #59 unable to reach the call bell at which time RN #8 was informed and unwrapped the call bell cord from the side rail and repositioned the call bell to be within Resident #59's reach. The facility policy labeled Call Bells indicated, in part, call bells should be positioned so Residents can easily access them when needed.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 46046 Based on review of the Resident Council Minutes and staff interview, the facility failed to ensure written responses to residents' concerns voiced about call bells within reach and or staff response time to call bells during Resident Council meetings were addressed timely by administration. The findings include. A review of the Resident Council Minutes from January 2024 through August 2024 identified residents expressed concerns regarding call bells being within reach and /or answered. Further review of the Resident Council Minutes identified the facility did not address the resident's call bell concerns until September 2024 minutes. An interview and interview with the Recreation Director on 10/07/24 at 11:04 identifed a form exists for Resident Council Concerns that are written and passed onto the appropriate person responsible for overseeing the concern. However the Resident Council forms had not been consistently used. The Recreation Director was able to provide 2 completed forms but was unable to provide forms for the other concerns voiced at Resident Council or any written responses to the monthly concerns voiced at Resident Council from February 2024 through August 2024 regarding call bells being answer. The Recreation Director further indicated s/he talked to the specific department head about the issues who would then address the concern, but s/he could not provide anything in writing. The Recreation Director further indicated the team would review the process and use the form to have a written history of the concerns being addressed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, review of facility policy and staff interview for the 1 resident (Resident #10) reviewed for Advanced Directives, the facility failed to ensure the resident's advanced directives were obtained timely and reviewed each care plan meeting. The findings include. Resident #10's diagnosis included severe dementia, hypertension, and hyperlipidemia. The admission Minimum Data Set, (MDS) assessment dated [DATE] indicated Resident #10 was moderately cognitively impaired. The Care plan dated [DATE] indicated Resident #10 had a progressive decline in intellectual functioning due to the dementia process. Interventions included: to gently redirect when exhibiting inappropriate action/behaviors, and to give one instruction at a time. However, further review identified no care plan was in place regarding advanced directives. An observation of the clinical record on [DATE] 8:38 AM (159 days after admission) identified a blank advanced directive forms in the clinical record with no indication of resident's code status/advanced directives identified in the electronic record. Interview and record review with Licensed Practical Nurse (LPN #6) on [DATE] at 12:00 PM identified she/he did not know why the advanced directives sheet was blank and indicated s/he would need to check with the nursing supervisor. LPN #6 further indicated if no advanced directives were in place the resident would be considered a Full Code and Cardiopulmonary Resuscitation (CPR) would be performed. An interview with LPN #6 on [DATE] at 1:50 PM identified s/he was able to have the advanced directives completed. LPN #6 further indicated s/he and the Director of Nursing Services (DNS) reviewed the chart and could not understand how the advanced directives for Resident #10 was overlooked. An interview with LPN #4 (MDS Coordinator Nurse) on [DATE] at 2:15 PM identified due to frequent absences of MDS staff advanced directives have not been routinely reviewed at care plan meetings by the team members in attendance. LPN # 4 further indicated after speaking with administrative staff, our team will start to review advanced directives at the care plan meetings moving forward. The facility policy labeled Advanced Directives given during the survey notes licensed nurse or attending physician will review the advanced directives with the capable resident or responsible party on admission to determine their wishes. In the event where a decision has not been decided the resident would remain a full code until determination was made.

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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** 50250 Based on clinical record review, observation and staff interviews for 1 of 6 sampled residents (Resident #415) reviewed for medication administration, the facility failed to notify the physician when the medication was not available for administration. The findings include: Resident #415 was admitted with diagnoses that included sepsis, dysphagia and generalized anxiety disorder. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #415 without cognitive impairment, was independent for personal hygiene, bed mobility and transfers. The Resident Care Plan dated 9/17/24 identified Resident #415 needed staff assistance with activities of daily living as needed. Interventions included providing setting up for Resident #415 at bedside or in bathroom and allowing the resident to do for him/herself what he/she and assisting when the resident cannot perform task. The physician's orders dated 9/17/24 directed to apply Kerasal Nail Renewal External Liquid to all toenails topically two times a day for toenail fungus for 6 weeks. Additionally, the order directed medication to be left with Resident #415 in bedroom. The Medication Administration Record (MAR) from 9/17/24 through 10/1/24 identified staff had been signing off the MAR for the resident's medication two times a day. Observation of medication administration for Resident #415 on 10/1/24 at 8:35 AM, with RN #2 identified she dispensed scheduled medications and administered them to Resident # 415 correctly. During medication review by the surveyor identified scheduled the resident's Kerasal Nail Renewal External Liquid medication that was due at the time of medication administration was not administered in presence of the surveyor. Interview with RN #2 on 10/1/24 at 12:25PM identified Resident #415 self-administers the medication and notifies the nurse when the medication is taken by him, the nurse then signs off the medication in MAR as administered. Interview with Resident #415 on 10/2/24 at 10:10 AM identified he/she requested that the physician prescribe the anti-fungal medication for his/her thickened toenails on 9/17/27. Resident #415 reported the medication had never been started nor given to him/her to keep in his/her room. Interview with RN #4 on 10/2/24 at 10:15 AM identified she did not administer the anti-fungal medication on 10/2/24 at 9:00 AM because she ran out of the medication and was going to re-order the medication from pharmacy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 10/2/24 at 1:30 PM identified she had inquired from the dispensing pharmacy about the medication who confirmed the medication was never dispensed. The DNS indicated pharmacy reached out to the facility to seek authorization/approval for the medication from the facility but the nurse supervisor who received the call forgot to escalate the issue to the right person since s/he could not authorize. The DNS was not able to explain why the nursing staff was signing off that the anti-fungal medication was being administered when it was never dispensed by pharmacy. After surveyor inquiry, the Advanced Practice Registered Nurse (APRN) was notified that Kerasal Nail Renewal External Liquid medication prescribed on 9/17/24 for Resident #415's toenails was never dispensed or administered to the resident. Interview with the APRN #1 on 10/2/24 at 3:20 PM identified Resident #415 requested the anti-fungal medication on admission due to thickened toenails. APRN #1 indicated that the medication was not prescribed for emergency reasons but was prescribed for comfort to the resident. APRN #1 stated she had not been notified for the past two weeks the medication was not being administered to the resident until today.

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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** 14448 Based on clinical record review, review of facility documentation, review of facility policy and staff interviews for 1 sampled resident(Resident # 64) reviewed for abuse, the facility failed to ensure the resident was free from physical abuse by Resident #36. The findings include: 1. Resident # 64's diagnoses included mild dementia without behavior disturbances, anxiety, mood disturbances, hypertension, thrombophilia, legally blind and paroxysmal atrial fibrillation. The MDS assessment dated [DATE] identified the resident was moderately cognitively impaired and had a history of rejection of care. The RCP for psychiatric drug use and potential for adverse side effects of psychotropic drug dated 6/6/24. Interventions included: to have Medical Doctor (MD) evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs and conduct vital signs per facility policy. The care card for June 2024 and August 2024 identified the resident required total care with bathing. 2. Resident # 36's diagnoses included diabetes type 2 without complication, chronic kidney disease stage 3, borderline personality disorder, benign prostatic hyperplasia with lower urinary tract symptoms, cardiac pacemaker and benign neoplasm colon. The physician's orders dated 6/11/24 directed to continue Trazodone 25 MG by mouth every 8 hours when needed for anxiety. The RCP for Mood state secondary to at risk for changes in mood due to depression, medication, sleeplessness/fatigue dated 5/24/24. Interventions included: to be aware of and report any changes in mental status, to encourage love one to keep in contact and to follow up with psychiatry as needed. Additionally, the care plan noted a notation dated 8/5/24 I squeezed my roommates face and punched both of his/her (Resident # 64) hands. Interventions noted I was immediately separated from my roommate , put on 1;1, evaluated by psychiatry and placed on Physician's Emergency Certificate (PEC). The nurse's notes dated 8/5/24 at 10: 31 PM identified the resident was witnessed being punch by roommate Resident # 36's bilateral hands; residents were immediately separated and 1:1 initiated. Resident #64 denies any pain on a scale (1-10). No sign of skin tear or bruising noted and indicated an Accident and Incident (A&I) report was started. Safety maintained and call bell within reach. The Reportable Event dated 8/5/24 identified Resident # 64 was observed by Nurse Aide (NA) being punched in the hand by Resident # 36 (roommate) who was alert and confused. Resident # 64 was assessed and identified with no redness or swelling and noted staff will continue to monitor. Additionally, not the resident's responsible party, MD and local police was notified of the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation dated 8/5/24 of Nurse Aide # 8 statement regarding the incident identified Resident # 64 was laying in bed when Resident # 36 held Resident # 64's wrist and was punching his/her hand. NA # 8 stopped Resident # 36 at the same time Resident # 64 was yelling someone is trying to break my wrist. Interview with the DNS and the Director of Social Service on 10/7/24 at 1:45 to 2:00 PM identified according to the nurse's notes and the Reportable Event Resident # 64 was observed by staff being punch in the hand by Resident # 36. The DNS further indicated Resident # 36 thought Resident # 64 was trying trip him/her by putting a pillow on the floor. The DNS indicated Resident # 36 was placed on 1:1 until transported to an acute care facility for an evaluation. She/he also indicated Resident # 36 had a history of aggression toward staff, likes to stay away from other residents but had no history of hitting residents. A review of the abuse policy dated 7/23/23 notes abuse or mistreatment of any kind toward a resident is prohibited. Allegations of abuse , by any individual (staff , family , visitors, resident) toward a resident must be reported immediately to a facility supervisor. All allegations will be thoroughly investigated and acted upon according to the steps of this policy.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 14448 Based on review of Resident Assessment and staff interviews for 4 of 6 sampled residents (Residents # 7, # 8, # 11 and # 35) reviewed for assessments, the facility failed to submit the residents' assessment timely. The findings include: A review of Residents # # 7, # 8, # 11 and # 35 Residents Assessment submitted to the state agency identified the residents assessment had not been submitted to the state agency for over 120 days. An interview with LPN # 4 (MDS Coordinator) identified she was out on a leave from the facility in July 2023, September 2023, October 2023 through December 2024 and was out again in February 2024 . LPN #1 indicated during her abscense the corporate staff was assisting the facility with completing and submitting MDS assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on clinical record reviews, facility documentation, facility policy, and interviews for 1 resident (Resident #166) reviewed for Specialized Treatment, the facility failed to ensure a care plan was in place. The findings included: 1. Resident #166 was admitted to the facility on [DATE] with diagnoses that included severe end stage renal disease with specialized treatment, diabetes mellitus, and polyneuropathy. A physician's order dated 4/11/23 directed a renal diet with a 2000 ml fluid restriction per day. The Specialized Treatment Center was on Monday, Wednesday, and Friday. The physician's orders dated 4/11/23 to 4/22/23 did not reflect where the resident's fistula was located or the monitoring of the fistula for a bruit and thrill every shift. The admission MDS assessment dated [DATE] identified Resident #166 had intact impaired cognition, was occasionally incontinent of bowel and bladder and required extensive assistance personal hygiene, dressing, and transfers. Resident #166 required set up and clean up for meals. Additionally, the MDS did not reflect Resident #166 was receiving specialized treatment. The Resident Care Card, baseline care plan nor the comprehensive care plan not dated did not identify that Resident #166 was receiving specialized treatment and had a fistula, location of the fistula, and the care and monitoring of the device. Interview with DNS on 10/1/24 at 3:25 PM identified a specialized treatment resident would have a physician order for the place and days where resident receives specialized treatment, the monitoring of the fistula for the bruit and thrill every shift, and the fluid restriction. After review of the clinical record the DNS indicated she did not see a physician's order to monitor the fistula for a bruit and thrill. The DNS indicated the nurse that did the admission was responsible for making sure the baseline care plan had the resident was a specialized treatment resident and the MDS nurse was responsible for making sure the comprehensive care plan had the specialized treatment and all the monitoring that goes with it per the policy. Review of the facility Hemodialysis Policy identified the physician order would include the name of the specialized treatment center, the frequency of the specialized treatments, and the monitoring and care needed for the fistula (dialysis site). Maintain fluid restrictions as ordered. Monitor intake and output and notify physician and specialized center if resident is non-compliant with fluid restriction. Additionally, observe specialized treatment site as ordered. Report any signs and symptoms of infection such as oozing, drainage, redness, or elevated temperature to the physician. Fistulas are monitored for bruit and thrill every shift and documented on the MAR or Treatment Administration Record (TAR). No blood pressures or blood draws to the arm with the fistula. Although requested, a facility policy for comprehensive care plan was not provided. 48792

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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** 42117 Based on review of the clinical record, facility policy and interviews for 1 of 6 residents (Resident #165) reviewed for care planning, the facility failed to revise the resident's care plan and care card related to resident's showers. The findings include: Resident #165 was admitted to the facility on [DATE] with diagnoses that included dementia, Covid-19, and weakness. A physician's order dated 10/21/22 directed to perform a body audit on admission and weekly on shower day by a nurse. The progress notes dated 10/21/22 through 11/4/22 did not reflect Resident #165 had refused a shower or that Resident #165 was provided a shower versus a bed bath weekly. The admission MDS assessment dated [DATE] identified Resident #165 had severely impaired cognition, was occasionally incontinent of bowel and bladder and required extensive assistance personal hygiene, toileting, and transfers. Additionally, Resident #165 indicated that it was very important to choose a shower, tub bath, bed bath, or sponge bath and needed moderate assistance for showers. The resident care card not dated did identify preference for a shower or bed bath but did not identify the day and shift the shower was to be performed by the nursing assistant. The baseline care plan not dated did not identify preference for a shower or bed bath or the day and shift shower was to be performed. The comprehensive care plan not dated did not identify preference for a shower or bed bath or the day and shift the shower was to be performed. The weekly shower schedule not dated identified Resident #165's bed bath was scheduled on Wednesdays 7-3 PM shift. Additionally, noted if a resident refuses their shower, please reproach and let the nurse know. This needs to be documented, Interview with DNS on 9/30/24 at 12:35 PM identified the nursing assistants know who to give a shower to each day based on the resident care card and there is a sheet at the nurse's station called the weekly shower schedule. The DNS indicated that if the resident does not receive their shower on their shower day and time the nursing assistant need to tell the charge nurse. The DNS indicated her expectation was the nurse would educate the resident on importance of taking a shower and if the shower was not given document, it in the progress notes. The DNS indicated if a resident refuses a shower but gets a bed bath it would be documented in the progress notes. Review of Resident #165's clinical record, the DNS indicated there were no progress notes identifying that Resident #165 had refused the showers and was given a bed bath. The DNS indicated that based on the nursing assistant documentation she could not identify if Resident #165 had a shower versus a bed bath. The DNS noted that the shower day and shift were not on the baseline care plan, comprehensive care plan or on the resident care card. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with DNS on 10/1/24 at 3:00 PM, failed to provide evidence that Resident #165 had received a shower while a resident at the facility. Although attempted, an interview with NA #4 was unsuccessful. Review of the facility Shower/Bathing Policy identified the purpose was to provide proper hygiene, stimulate circulation and promote skin integrity. Each resident will be offered a full bath or shower at least weekly. Review of the facility Resident Rights Policy identified the resident had the right to receive quality of care and services with reasonable accommodation of your needs and preferences. The resident have the right to make choices about aspects of life that were significant to him/her. The resident or resident representative have the right to participate in planning their care and treatment. 46046

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14448 Based on observations, clinical record reviews , facility policy and staff interviews for 1 resident reviewed for hospitalization (Resident #6), the facility failed to ensure medication was available for the resident and for 3 of 3 residents reviewed for bathing(Residents #26, 27 and #52), the facility failed to ensure staff consistently provided evidence of the provision of showers, and for 1 resident (Resident #215), reviewed for admission nursing assessment, the facility failed to ensure a body audit was completed on admission to ensure treatment orders were followed as prescribed by the physician and for 1 of 6 sampled residents (Resident #415) reviewed for medication administration, the facility failed to initiate a new treatment order per physician and for 1 of 2 residents (Resident # 64) reviewed for intake and output, the facility failed to consistently monitor the resident's output according to the plan of care and facility policy .The findings included: 1. Resident #6's diagnosis included hypertension, heart failure, liver cirrhosis. A physician order dated 8/17/2024 directed to provide Rifaximin 550 MG one tablet by mouth twice daily related to liver cirrhosis. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 had mild cognitive impairment. An interview and clinical record review with the DNS on 10/7/2024 at 2:12 PM identified the following: The omissions of Rifaximin 550 MG 6 times from admission from 9/17/2024 through 9/30/2024 since transferred to the facility. Further review of the administration of the medication Rifaximin 550 MG tablet to Resident #6 identified the medication was unavailable or the resident did not receive on 8/18/2024 at 8:02 PM, 8/19/2024 at 8:06 AM, 8/23/2024 at 8:13 PM, 8/26/2024 at 8:04 PM, 8/29/2024 at 8:10 PM and no evidence the resident received the medication on 8/21/2024 for the 8:00 PM dose. The DNS indicated s/he could not explain why the resident's medication was not available. An interview with Pharmacy Medical Records Person #1 on 10/7/24 at 2:40 PM identified the medication had never been sent because of the insurance. An interview with Pharmacist #1 on 10/7/24 at 2:42 PM on 8/16/2024 identified the medication order was not filled and s/he request for authorization for payment be sent to the facility (for facility to authorize to pay for the prescription). Pharmacist # 1 further indicated on 8/17/2024 the authorization form was returned to the pharmacy indicating Do Not Fill. Although the pharmacist was asked what effect would not receiving the Rifaximin as ordered be on Resident #6, s/he did not provide an answer. Attempts to reach the Medical Director on 10/7/2024 at 3:00 PM were unsuccessful. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and record review with the DNS on 10/7/2024 at 3:15 PM identified a medication delivery sheet with multiple medications was sent from the pharmacy on 10/17/2024 indicating 14 tablets (7 days of the medication, 2 tablets twice daily) was accepted by the facility, but the DNS could not indicate why the medication if received was not available to give to the resident or why it was not reordered after the 7 day supply exhausted leaving Resident #6 without the medication and found no indication of the physician being notified that Resident #6 was not provided 6 doses of the medication as ordered. Resident #6 was transferred to the hospital on 8/30/2024. The facility policy labeled, Medication Administration indicated in part all medications will be administered safely and accurately in accordance with physician's orders and document on the Medication Administration Record (MAR) immediately after giving the medication. 2. Resident #26's diagnosis included osteoarthritis and osteoporosis. The care plan dated 7/30/2024 indicated Resident #26 required assistance with activity of daily living. Interventions included: to assist resident with Activities of daily living after allowing Resident #26 to complete as much care independently as able. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #26 was cognitively intact and required substantial assistance for showering. An interview and clinical record review with the DNS on 10/7/2024 at 1:30 PM indicated a shower was provided on 9/4 and 9/8 and 9/25/2024. However, no evidence of a shower was provided from 9/9/24 through 9/24/2024 (16 days) in the clinical record. 3. Resident #27's diagnosis included chronic pain and hypertension. The quarterly MDS assessment dated [DATE] indicated Resident #27 was cognitively intact and required substantial assistance with showers. The care plan dated 9/26/2024 indicated Resident #27 required assistance with activities of daily living (ADL's). Interventions included: to assist with ADL as needed due to fluctuating ability. An interview and clinical record review with the DNS on 10/3/2024 at 1:40 PM indicated showers were documented as provided on 9/7 and 9/14/2024 with no evidence of a shower provided from 9/15/2024 -9/30/2024 (16 days) in the clinical record. 4. Resident #52 diagnosis included anxiety depression and traumatic brain injury. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #52 was cognitively intact and was dependent for shower transfer. The care plan dated 9/10/2024 indicated Resident #52 required assistance from staff for activities of daily living (ADL's)with interventions including to assist with toileting and dental care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the clinical record for bathing with the DNS on 10/7/2024 at 1:40 PM of review of the nurse aide documentation for September 1 through 30, 2024 identified showers given on 9/4, 9/18 and 9/27/2024 and no shower given for 12 days (9/5/24 through 9/17/2024). Additionally, the review noted no documentation for September 2024 on the day shift,9/23/24 and 9/28/24 and on the evening shift 9/2, 9/3, 9/6, 9/7, 9/12 ,9/15, 9/23, 9/25, and 9/29/2024. On 10/3/2024 from 1:30 to 1:45 PM the DNS indicated showers were scheduled weekly on a master shower schedule for each facility bed. The nurse aide paper care cards and electronic documentation are updated with any changes. The DNS did not know why the master shower list did not match the shower days on the nurse aid care cards or know the reason for missing evidence or documentation the missing showers were provided. The DNS further indicated the nurse aids have codes to document if a resident refuses care, if it is not applicable, or if care is provided. The DNS also indicated if a resident refuses care, nurse aides are to inform the charge nurse who will document the refusal in a nurses note. However, no nurse aide documentation or nurses notes to support refusal were provided. 5. Resident #215's diagnosis included a history of falls, sprain of ligaments of the cervical spine and contusions of the lower back and pelvis. Resident #215 was admitted to the facility on [DATE]. The hospital discharge summary dated 9/27/2024 at 11:44 AM indicated in part a foam dressing with medical grade honey was in place on the resident's left arm over a skin tear and noted the area was dry and intact. Additionally, the discharge summary noted the resident would also need follow up for a chronic wound on the ankle. A review of the clinical record identified no nursing assessment or body audit was documented on admission. a nursing note dated 9/27/2024 at 12:54 PM indicated Resident #215 was admitted to the facility with skin intact and noted bruises and scabs from a previous fall. The nurse's notes also indicated to see the nursing assessment (body audit). The care plan dated 9/27/2024 indicated in part Resident #215 was admitted for short term rehabilitation. Intervention included: to establish a discharge plan and noted the social worker to assist the resident/family with discharge planning as appropriate. An observation on 10/03/24 at 8:00 AM identified Resident #215 was noted with one wound dressing on the left elbow and three wound dressings on the right knee all dated 9/26/2024. Resident#215 indicated the wound dressings had been applied prior to admission to this facility. Also observed was a scab with surrounding redness on the left outer ankle. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/03/24 at 8:20 AM during observation and interview with RN # 4 (nursing supervisor) during record review identified she/he worked as the charge nurse on the unit, and s/he found the dressings dated 9/26/2024 for the left outer ankle scab with surrounding redness. The RN# 4 supervisor after assessing the outer left ankle indicated to Resident #215, he/she would return to remove the dressings and assesses and measure the wounds. RN #4 indicated s/he does not know how the dressings could have been overlooked and with review of the Resident # 215's record although a nurses note indicated a nursing assessment had been completed on admission, no admission nursing assessment could be found in the clinical record. Further clinical record review with RN #4 identified a weekly skin assessment completed on 9/30/2024 3 days after admission which indicated no new findings, and no wound treatment orders were found. RN#4 further indicated the dressings should have been removed on admission, the wounds assessed, measured, and wound orders obtained from the physician. RN # 4 further indicated the nurse who completed the skin assessment on 9/30/24 should have noticed and questioned the date of the dressing in place. An interview with the DNS on 10/03/24 at 9:40 AM indicated a complete body audit would be done, and it was out of character for the nurse (RN #8) who was assigned the admission body audit not to have documented the assessment. The DNS also indicated there was no 24-hour report between each shift for the supervisor to maintained to view' On 10/3/2024 at 10:28 AM attempts to contact RN #8 were unsuccessful. An interview with RN #2 at 10:35 AM, the nursing supervisor on 10/3/2024, indicated s/he could not recall Resident #215. On 10/03/24 at 10:58 AM an attempt to reach RN # 9 the charge nurse on 9/30/2024 who completed the body audit was unsuccessful. After surveyor inquiry, a body audit was completed on 10/3/2024 which identified multiple scabbed areas from a fall at home noted on the bilateral lower extremities and an opened reddened area where a scab fell off noted on the left elbow, blanchable redness noted to the coccyx area. Although a request was made for treatment orders obtained after the body audit and wound assessment on 10/3/2024, none were provided. The facility policy labeled Admission/Readmission of A Resident indicated in part on admission the Intra-Agency discharge summary and nursing summaries are to be compared. If any discrepancies are identified, they are to be clarified and the attending physician is notified to verify medication and other orders written on the discharge paperwork. The policy further indicated the unit nurse would be responsible for completing all nursing assessments. 6. Resident #415's diagnoses included sepsis, dysphagia and generalized anxiety disorder. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #415 without cognitive impairment and noted the resident was independent for personal hygiene, bed mobility and transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 9/17/24 identified Resident #415 needed staff assistance with activities of daily living as needed. Interventions included: setting up Resident #415 at bedside or in bathroom and allowing him/her to do for him/herself what he/she can and assisting with what the resident cannot do. The physician's orders dated 9/17/24 directed to apply Kerasal Nail Renewal External Liquid to all toenails topically two times a day for toenail fungus for 6 weeks. Additionally, the order directed medication to be left with Resident #415 in bedroom. The Medication Administration Record (MAR) from 9/17/24 through 10/1/24 identified staff had been signing off the medication as given two times every day. Observation of the MAR for Resident #415 on 10/1/24 at 8:35 AM, with RN #2 identified she dispensed the resident's scheduled medications and administered them to Resident # 415 correctly. During medication review identified Resident # 415's scheduled Kerasal Nail Renewal External Liquid medication that was due at the time of medication administration was not administered in presence of the surveyor. However, the medication was signed off in the Medication Administration Record as administered. Interview with RN #2 on 10/1/24 at 12:25PM identified Resident #415 self-administers the medication and notifies the nurse know when Resident # 415 self-administers the medication, and the nurse then signs off the medication in MAR as administered. Interview and record review with the DNS on 10/2/24 at 9:30 AM failed to identify that a self-administration of medication assessment was completed for Resident #415 prior to the initiation of the anti-fungal medication. The DNS identified Resident #415 was alert and oriented and was admitted for short term rehabilitation. DNS further indicated that a self-administration assessment should have been completed by the nurse prior to the initiation of the anti-fungal medication. Interview with Resident #415 on 10/2/24 at 10:10 AM identified that he/she requested the physician to prescribe the anti-fungal medication for his/her thickened toenails on 9/17/27. Resident #415 reported the medication had never been started nor given to him/her to keep in his/her room. Interview with RN #4 on 10/2/24 at 10:15 AM identified she did not administer the anti-fungal medication on 10/2/24 at 9:00 AM because she ran out of the medication, and she was going to re-order the medication from pharmacy. Follow up interview with the DNS on 10/2/24 at 1:30 PM identified that she had inquired from the dispensing pharmacy about the medication who confirmed the medication was never dispensed. The DNS indicated that pharmacy needed authorization/approval of the medication from the facility but the nurse supervising who received the phone call forgot to escalate the issue to the right person therefore s/he could not authorize for the medication to be dispensed. The DNS was not able to explain why the nursing staff was signing off that the anti-fungal medication was being administered when it was never dispensed by pharmacy. Interview with the APRN #1 on 10/2/24 at 3:20 PM identified Resident #415 requested for the anti-fungal medication on admission due to thickened toenails. APRN #1 indicated that the medication was not for emergency reasons but was for comfort to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedures titled General Dose Preparation and Medication Administration directed, in part the facility staff should verify the medication being administered is the correct medication, the correct dose, the correct route, the correct time and the correct resident prior to and during medication administration. 7. Resident # 64's diagnoses included mild dementia without behavior disturbances, anxiety, mood disturbances, hypertension, thrombophilia, legally blind and paroxysmal atrial fibrillation. The MDS assessment dated [DATE] identified the resident was moderately cognitively impaired and had a history of rejection of care. The RCP for psychiatric drug use and potential for adverse side effects of psychotropic drug dated 6/6/24. Interventions included: to have Medical Doctor (MD) evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs and conduct vital signs per facility policy. A review of Resident # 64's From April 29, 2024 through 6/9/2024 identified the resident's out put was not monitored all three shift according to intake and output sheet and the plan of care. Record review and interview with the DNS on 10/7/24 at 2: 30 PM and prior to exit identified she/he could not provide the missing outputs. Review of the hydration Policy identified all nursing was responsible for recording intake and output. The nurse is responsible for ensuring proper dating of intake and output is in place with the fluid restriction and completing the subtotal at the end of the shift. Intake and outputs will be totaled for all three shifts at the end of the 24-hour period by the nurse. Never leave a column blank. Place a zero and notify the nurse. 37721 46046 50250

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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** 48792 Based on clinical record review, review of facility policy and staff interviews for 1 of 4 residents reviewed for accidents (Resident #52) the facility failed to provide the necessary supervision and to educate staff regarding interventions for 1:1 monitoring in common area to ensure a safe environment. The findings include: Resident #52's diagnoses included opioid dependence, depression, and generalized anxiety disorder. A physician's order dated 11/16/23 identified Resident #52 was on a Methadone Maintenance Program for substance abuse disorder. The admission Minimum Data Set assessment dated [DATE] identified Resident #52 was cognitively intact and required maximum assistance with eating, oral hygiene, and was dependent for personal hygiene. A nurse's note dated 1/14/24 at 12:57 PM identified Resident #52's evening medications were not administered as resident was lethargic. Resident admitted to RN supervisor that s/he snorted heroin in her/his room on Friday night and Saturday night. The resident also stated a friend was visiting on Friday night and s/he was snorting heroin in her/his room and gave resident some. A nurse's note dated 1/14/24 at 1:30 PM stated that a message was placed on Resident #52's door directing all visitors to report to the nursing station before entering. The acknowledgement form for Prohibited Items in the Environment policy was signed by the resident on 1/14/24. The Resident Care Plan dated 1/15/24 identified Resident #52 was receiving methadone and admitted to snorting heroin in the facility on 1/12/24 and 1/14/24. Interventions included that all visits would be 1:1 ongoing. In an interview with DNS on 10/2/24 at 11:00 AM identified the resident was unresponsive and lethargic with low oxygen saturation levels on 1/14/24. Once resident became alert, s/he stated that s/he admitted to taking heroin that a friend brought into the facility. The DNS updated the Resident Care Plan and the nurse's aide care card to include all visits had to be monitored 1:1 in a common area. The DNS stated that a sign was posted on the resident's door requesting all visitors report to the nursing station before entering. The DNS also stated she did not educate staff to the interventions as they are required to review the care plan and care card every shift. The DNS confirmed that she notified the resident's Power of Attorney (POA), and s/he agreed with interventions. Although requested, a copy of the visitor log for 1/12 through 1/18/ 2024 was not provided. The DNS stated she could not find the missing log but there was no evidence in the log Resident #52 had visitors from January 12, 2024, through January 18, 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/2/24 at 12:20 PM with NA #6 identified she went in to provide morning care and found Resident #52 unresponsive and got the nurse. The head nurse sent her to the emergency room (ER). NA#6 did see a visitor in Resident # 52's room that morning and reported it to the charge nurse and the supervisor. NA # 6 was not aware that the resident was not supposed to have visitors in her/his room. In an interview on 10/2/24 at 12:45 PM with DNS to discuss the incident on 1/18/24. The DNS indicated s/he was not aware Resident # 52 had a visitor in her/his room on 1/18/24 prior to becoming unresponsive. The DNS was not sure why the NA was not aware of the visitor restrictions as the intervention was on the care plan. Furthermore, the DNS stated the sign was removed from the door requesting visitors to report to the nursing station prior to entering the room. It was removed for confidentiality reasons. In an interview with RN#2 on 10/2/24 at 2:00 PM identified s/he was aware of the visitor the morning of 1/18/24 as resident told her/him. RN #2 was not aware that all visits were to be 1:1 and in a common area. RN#2 indicated she was unaware because she doesn't usually work on that unit. RN #2 did confirm that s/he was the supervisor when s/he worked on the unit. RN#2 indicated s/he should have known about the 1:1 visitor in the common area. In an interview on 10/4/2024 at 2:16 PM with the DNS identified the nursing/aide staff were not educated regarding interventions on the care plan that instructed all visits must be 1:1 with staff. The DNS indicated the nurse aides all have access to the care plan and care cards. DNS identified the facility do not have a shift report in place at this time. DNS also identified there is no receptionist on the weekends at the front desk. Although requested, a copy of the visitor log for the period of 1/12/24 through 1/18/24 was not provided. The DNS stated they could not find it, however there were no visitors signed in for that time on the log for Resident #52.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on review of the clinical record, facility policy and interviews for 1 of 2 residents reviewed for nutrition (Resident # 57), the facility failed to ensure monthly weights were completed in the clinical record. The findings include: Resident #57's diagnoses included Type 2 diabetes mellitus and hypertension. The Resident Care plan dated 7/24/24 indicated Resident #57 has the potential for a nutritional decline related to recent hospitalization . Intervention include weigh as ordered. The Minimum Data Set assessment dated [DATE] noted resident is cognitively intact and is independent with eating but requires set up for oral hygiene. A physician's order dated 1/15/24 directed weigh weekly for 4 weeks every evening shift for 30 days. No follow up orders noted. Review of Residents #57 Weights identified missing weights for the months of January, February, May, June and August 2024. Interview with RN #5 on 10/07/24 10:42 AM indicated weights should be done monthly after admission period (weekly for 4 weeks) and indicated weights frequency is documented based on recommendation of doctor or dietician. Documents provided on 10/07/24 at 11:35 AM by RN #5 identified the resident's weights were missing for January, February, May, June and August 2024. During interview RN#5 identified the facility's expectation is that weights are performed and documented monthly. She/he also reported NAs are responsible for obtaining weights and nursing staff are responsible for documenting weights in the clinical record. Interview with the Dietician on 10/07/24 at 11:59 AM indicated Residents #57 weights are documented in the electronic records. The Dietician also indicated given the missing weights in the electronic records not completed or performed by staff she would speak with NAs and nursing to get an understanding on the residents eating habits and any identified concerns. The Dietician further indicated the expectation is to see weekly weights for 4 weeks (on admission) then monthly unless deems at nutritional risk by self or MD. The Dietitian indicated Resident #57 was not deemed at risk, therefore, it is the expectation that resident has monthly weights conducted. The Dietician reported missing weights could affect how s/he determines weight loss or gains. Facilities Weight Monitoring Policy indicated weights should be taken monthly unless otherwise indicated by the MD order and/ or recommended by Registered Dietician. Policy further indicated, residents will be weighed during the first 7 days of the month. Weights will be taken and recorded on the weight's sheets or in the facility software.

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on observations, clinical record reviews, facility policy and interviews for the 2 of 2 sampled resident (Residents # 40 and # 366) reviewed for Respiratory Care and utilized oxygen, the facility failed to administer oxygen per physician's order and label the oxygen tubing per facility practice The findings included: 1. Resident #40's diagnoses included diabetes mellitus, hypertension, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was severely cognitively impaired, was dependent on staff for personal hygiene and toileting and required maximum assistance for bed mobility. Additionally noted no utilization of oxygen therapy. The Resident Care Plan dated 10/1/24 identified Resident #40 was at risk of cardiac issues related to cardiovascular disease. Interventions included: checking oxygen saturation as ordered and per policy, monitoring for signs and symptoms of respiratory distress, and encouraging rest periods as needed. Observations on 10/1/24 at 10:30 AM, 10/2/24 at 9:40 AM and 10/03/24 09:14 AM, identified Resident #40 utilizing oxygen at 4.0 Liters Per Minute (lpm) via a nasal cannula. Interview, observation, and clinical record review with LPN #5 on 10/2/24 at 9:40AM identified Resident #40 was utilizing oxygen via a nasal cannula at 4.0 lpm. LPN #5 was not able to locate any active oxygen physician orders but could only locate a discontinued order to titrate for oxygen below 92% on 3/29/24. LPN #5 stated Resident #40 was dependent on oxygen at 4.0 lpm for at least a few weeks since the resident was moved from the rehabilitation unit to the current unit. LPN #5 could not explain why Resident #40 did not have an active oxygen order for the 4.0 liters per minute and indicated there should have been a physician's order for the oxygen. Interview and clinical record review with the DNS on 10/2/24 at 11:30 AM identified Resident #40's oxygen therapy was started in March 2024 of this year. The DNS was not able to locate a current active oxygen order or any discontinued oxygen order for this resident. The DNS was only able to locate a discontinued order to titrate for oxygen below 92% on 3/29/24. The DNS could not explain why Resident #40 was on oxygen therapy without a physician's order. Additionally, the DNS indicated any charge nurse can initiate a physician's order for oxygen with physician's approval. 2. Resident #366 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), dysphagia, and hypothyroidism. The RCP dated 8/26/24 indicated Resident # 366 was at risk for respiratory distress, ineffective breathing patterns. Interventions include to provide oxygen as ordered by my MD, follow facility policy regarding changing of my oxygen tubing, oxygen saturation as ordered/per policy and to provide medication(s) as per my MD orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 9/10/24 directed Continuous Oxygen at 4 Liters per Minute Via Nasal Cannula related to hypoxia every shift and Change oxygen tubing and humidifier canister weekly on Saturday Observation on 9/30/24 at 12:06 PM identified Resident#366 oxygen nasal cannula was on 3 liter, and oxygen tubing was not labeled. Observation on 10/01/24 at 10:40 AM oxygen identified the resident's oxygen at 3 liters and nasal cannula observed to be on resident's chest. Interview with LPN#2 on 10/01/24 at 10:45 AM. identified she was not sure why oxygen nasal cannula was 3 Liters instead of 4 liters per physician's order and indicated the facility practice is to have the oxygen tubing labeled, however, s/he was unsure why it was not labeled. LPN # 2 further indicated the MD and APRN are responsible for making orders. After surveyor inquiry, the physicians' orders dated 10/1/24 directed Continuous Oxygen at 3 Liters per Minute Via Nasal Cannula On 10/01/24 at 2:49 PM after surveyor inquiry, LPN #2 indicated the oxygen tubing was labeled. LPN #2 indicated staff are now monitoring Resident's Oxygen status given the changed orders to reflect 3 liters. Per facility Oxygen Administration policy indicated A physician 's order is necessary for the administration. . 50250

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations, clinical record review and staff interviews for 1 resident (Resident # 215) who had a food allergy to eggs, the facility failed to ensure a food item listed as an allergy was not served to the resident. The findings include: Resident #215 was admitted on [DATE] with diagnoses which included cellulitis of the lower limb, dysphagia and anxiety. The admission Nursing assessment V6 dated 9/29/2024 at 9:59 PM indicated in part Resident #215 had an allergy to eggs. The diet slip dated 9/29/2024 completed by the admitting RN indicated Resident #215 had eggs as a pertinent food allergy. The care plan dated 9/30/2024 indicated Resident was planning for discharge after short term rehabilitation. Interventions included: to facilitate a discharge plan with the resident/family when appropriate. An interview with Resident #215 on 9/30/24 at 1:08 PM identified she/he received French toast which is made with eggs at breakfast and after telling the server s/he was not able to eat eggs plain toast was provided instead. An interview with the Dietary Manager on 10/1/2024 at 10:50 AM who was also working as the cook identified she/he could not update the diet slips until after breakfast on 9/30/2024 and Resident #215's egg allergy was written in RED and indicated whoever is serving the food goes by the slip. The Dietary Manager also indicated on 9/30/2024 there was no diet slip for Resident #215 and the staff must have just offered Resident #215 the plate. The Dietary Manager further indicated if there is a question regarding a resident's diet or if the resident is a new admission and no dietary slip was available, the staff should ask the nurse on the unit to clarify before providing to the resident. The Dietary Manager further indicated he/she would be talking to the [NAME] #1 who worked 9/30/2024 at breakfast. On 10/02/24 9:40 AM an observation of the steam table plating and serving on the unit where Resident #215 resided, identified [NAME] #1 at 9:50 AM plated scrambled eggs and indicated to the server (Dietary Aide #1), to bring to Resident #215. Once again Resident #215 indicated to the server Dietary Aide #1 the plate contained eggs, the Dietary Aide read the Resident # 215's diet slip and noted it said allergy to eggs and brought the plate out of the room and notified [NAME] #1. On 10/2/2024 at 9:53 AM an interview with [NAME] #1 regarding why scrambled eggs were plated for Resident #215 when the diet slip prominently displayed an allergy to eggs typed in RED ink, identified there was not a diet slip yesterday so s/he just plated even though the diet slip had to be handled and given to Dietary Aide #1. (continued on next page)

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	075089	A. Building B. Wing	10/07/2024

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/2024 at 9:58 AM an interview with the DNS after being informed of the incidents of Resident #215, with a listed egg allergy, being provided eggs on 2 occasions indicated they would be looking into the situation immediately. On 10/2/2024 at 10:00 AM an interview with the Dietary Manager identified there was a posted a read and sign Inservice on the bulletin board outside the Dietary Manager's office for staff to read regarding the use of the new diet slip program which started several weeks ago. However, [NAME] #1 had not signed. The Dietary Manager had no reason why s/he allowed [NAME] #1 to serve residents using the new diet slips after not having completed the in-service regarding the new diet slips but indicated s/he would have a discussion with [NAME] #1. After surveyor inquiry, on 10/2/2024 12:00 PM the Dietary Manager provided an in-service form dated 10/2/2024 indicating [NAME] #1 and Dietary Aide #1 were in-serviced regarding the need to read the diet slips for any allergies before serving the residents.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 1 of 2 sampled residents (Resident # 365) reviewed for bladder and bowel incontinence, the facility failed to ensure a complete and accurate record regarding the resident's care. The findings include: Resident #365 was admitted on [DATE] with diagnoses that included muscle weakness, hemiplegia (paralysis) affecting right side and anxiety disorder. The nursing admission assessment dated [DATE] identified Resident #365 as alert and oriented, continent and incontinent of urine and bowel and required one-person assistance with personal hygiene, bed mobility and transfers. An interview with Resident #365 on 10/1/24 at 9:00 AM identified s/he was soaked in urine and was not changed by staff on 9/29/24 from 6:00AM until 12:00PM. Resident #365 identified that the call bell was out of reach and when a female staff entered her/his room, s/he expressed her/his concerns to the female staff who encouraged him/her to use his/her call bell to seek staff attention. Resident #365 stated s/he panicked and was unable to express him/herself any further because s/he could not reach her call bell. Review of Resident's # 365's clinical record on 9/20/24 through 10/1/24 failed to reflect documentation of the resident's bladder and bowel elimination care provided on 9/29/24 on the 7:00AM to 3:00 PM shift. Further review of Resident # 365's clinical record, failed to identify documentation for bladder and bowel elimination care provided on the 7:00AM to 3:00 PM shift on 9/23/24, 9/26/24 and 9/29/24, 3:00 PM to 11:00 PM shift on 9/20/24 and 9/28/24 and 11:00PM to 7:00 AM shift on 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/29/24, and 9/30/24. An interview with Nurse Aide (NA #5) on 10/3/24 at 11:30 AM identified she worked first shift on 9/29/24 and had been assigned to take care of Resident #365. NA #5 stated she had provided incontinent care to Resident #365 but could not recall what time s/he had provided the care. NA #5 further indicated that due staff shortage, s/he was unable to complete documentation on care s/he provided to Resident #365. NA #5 identified that it is a requirement that care provided to residents are documented by the end of each shift. An interview and record review with the Regional Staff RN #2 on 10/3/24 at 11:15 PM identified bladder and bowel elimination care for Resident #365 was not consistently documented on each shift. The RN #2 identified that NAs are responsible for documenting care provided by the end of each shift and that charge nurse is responsible for ensuring NAs document care they provided to residents. RN # 2 could not explain why the resident's bladder and bowel care was not documented on each shift while Resident #365 was admitted in the facility. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview and Record Review with RN #4 on 10/3/24 at 2:22 PM identified NAs are responsible for documenting care provided to residents in clinical record by the end of each shift. RN #4 further stated she was responsible for overseeing that care provided was documented in residents' clinical record. RN #4 however identified that she assumed NA #4 would document care s/he provided to Resident #365 on her/his shift despite staff shortage. An interview and record review with the DNS on 10/3/24 at 2:30 PM identified s/he was not aware of the incident on 9/29/24 and Resident #365 had already been discharged on [DATE]. The DNS also could not explain why the resident's bladder and bowel care was not being documented on each shift but stated she would follow up with staff. After surveyors inquiry, the bowel and bladder care in question on 9/29/24 7:AM to 3:00 PM shift was dated back and documented for 9/29/24 2:59 PM. The facility policy for Nursing Documentation in the Medical Record directed, in part documentation should be completed as soon as possible after care is provided ideally within the same shift .If a late entry is necessary, ensure it is clearly identified in the electronic system, documenting the exact date and time of the event being recorded.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48880 Based on observations, review of facility documentation, and staff interviews, the facility failed to maintain the dry food storage to ensure the area was free from insects and failed to follow recommendations their pest control program. The findings include: The facility pest control log identified a service report by an outside pest control company dated 6/22/24 indicating one fly light was installed in the kitchen storage area. The service report also indicated, under a sanitation/housekeeping section, that bananas needed to be covered. A Pest Control Service Report dated 7/26/2024 indicated fruit flies were noted by a food cart in the hallway and that recommendations were to remove the carts from the hallway. The service report further indicated treatment for fruit flies was applied to the kitchen and hallway. On 9/30/24 at 10:35 AM, a tour of the facility kitchen with the Director of Dietary #2 identified a large cardboard box in the corner of the dry storage room that contained many bananas with the majority of them ripe with black and brown spots and several bananas that were completely black in color. The box was uncovered, and many fruit flies were observed flying above it. Dietary Director #2 indicated s/he did not know how long the bananas were there. An interview with Dietary Manager #1 identified the bananas had been delivered on 9/24/2024 with the last vendor delivery. Additionally, Dietary Director #1 indicated there was no plan on the menu for the bananas and they would be thrown away since there would be a new delivery on 10/1/2024. Dietary Director #1 further indicated the dry storage had a fly light installed for control of fruit flies but s/he was not sure how long ago and indicated that records would be with the maintenance department. On 10/3/2024 at 11:30 AM, a follow-up interview with Dietary Director #1 indicated s/he was not aware the facility's pest control contractor had recommended that bananas be covered. Dietary Director #1 indicated s/he does not review pest control service reports and that the reports are reviewed by maintenance. In an interview on 10/3/2024 at 11:40 AM, the Director of Maintenance indicated s/he is responsible for reviewing the pest control logs and s/he was not aware of the recommendations for covering bananas made on 6/22/2024. Additionally, the Maintenance Director indicated the kitchen should have been aware of the recommendations since the kitchen had requested pest control services for 6/22/2024. Attempts to interview the pest control company were unsuccessful.