

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab Guilford		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Boston Post Rd Guilford, CT 06437	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #16) reviewed for dignity, the facility failed to ensure staff treated the resident with dignity. The findings include:</p> <p>Resident #16 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder, mood disorder, morbid obesity.</p> <p>The quarterly MDS dated [DATE] identified Resident #16 had intact cognition, had upper and lower extremity impairments on both sides, was dependent on rolling left and right, refused chair/bed-to-chair transfers, was on a scheduled pain regimen, and received PRN (as needed) pain medication in the last 5 days.</p> <p>The care plan dated 8/7/24 identified Resident #16 required staff assistance with ADL's due to decreased range of motion to the upper and lower extremities. Interventions included incontinence care per policy and per resident request to be out of bed within half an hour of the specified time and back to bed as needed for naps and incontinent care. Resident #16 had accusatory and manipulative behaviors and voiced delusions and hallucinations. Interventions included frequent documentation of all abnormal behaviors, episodes of confusion, yelling out, and delusions to help assess what medication interventions are needed, per the APRN, assist of 2 for all care, and approach in a calm manner. The care plan further identified Resident #16 could be impulsive and not always able to control his/her behavior. Interventions included if staff see Resident #16's mood changing, offer to assist him/her to another area and spend a few minutes in quiet conversation until the anger subsides.</p> <p>The Social Service note dated 10/3/24 at 3:42 PM identified that Resident #16 reported to the social worker that two nurse aides were unpleasant during a transfer with a hooyer lift. Resident stated that his/her right leg was often sore and during the transfer the leg was bumped, reported the concerns to the DNS.</p> <p>The Reportable Event Form dated 10/4/24 at 2:00 PM identified Resident #16 reported to the social worker that two nurse aides were not pleasant to him/her while they provided assistance with a transfer via mechanical lift. The resident was reassured of safety, nurse aides have been suspended pending investigation.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>NA #4's statement identified that on 10/3/24 at 1:00 PM, before they entered Resident #16's room, NA #3 indicated to NA #4 that she would remain silent while caring for the resident because of the residents past threats and reported allegations of nurse aide terminations. NA #3 and NA #4 changed the resident's clothes, provided care, and utilized a hooyer lift for the transfer. A third nurse aide, NA #2, assisted with the transfer. The transfer was done safely and with precautions. After securing the resident in the chair, he/she thanked the nurse aides, and all three nurse aides left the room to continue with our duties.</p> <p>NA #3's statement identified that on 10/3/24 at approximately 1:00 PM, she assisted NA #4 with Resident #16's care. Prior to entering the room, NA #3 communicated that she would remain silent because the resident had previously made threats and claimed to have had other nurse aides fired. Resident #16 had expressed no desire for NA #3's termination but for a suspension, which was brought to the Administrator's attention and the attention of the overnight supervisor. Upon entering Resident #16's room, his/her clothes were changed, and care was provided without verbal interaction from NA #3 to the resident. NA #3, NA #4 and NA #2 safely transferred Resident #16 from the bed to the wheelchair.</p> <p>NA #2's statement identified that Resident #16 had asked NA #2 to assist NA #3 and NA #4 with the transfer. After the transfer, Resident #16 was complaining that he/she was not sitting correctly. NA #2 tilted the seat back so they could get Resident #16 into the right place. NA #2 held the resident's foot out of the way while NA #4 pulled him/her back in the chair and NA #3 lowered the resident into it. Once seated, NA #2 adjusted the wheelchair back to the correct position. When NA #2 was about to walk out the door and leave, Resident #16 said, thank you to NA #2. Subsequently, NA #3 stated to the resident, (Thank you NA #2? There were two other people here). NA #2 indicated she heard that as she left the room but heard nothing else.</p> <p>The Reportable Event Summary dated 10/8/24 identified that Resident #16 reported that 2 nurse aides (NA #3 and NA #4) were unpleasant. Resident #16 indicated that NA #3 said let me do my job, and during the transfer his/her leg hit the lift, and it was very painful. Resident #16 later called for assistance from NA #2 because she knew how to accurately position the resident. NA #2 assisted NA #3 and NA #4 and when they were done Resident #16 indicated that he/she said, (Thank you, NA #2), and NA #3 made a comment that 3 nurse aides provided assistance and only NA #2 was thanked. Resident #16 indicated that the comments were full of sarcasm and were not appreciated. Based on the investigation including physical and clinical findings, there was not sufficient evidence that the resident's right leg was injured during the transfer from bed to motorized wheelchair. The physical presentation, chronic condition of the right leg, and findings of pain on light palpation were evidence that the leg was sensitive to light touch, and pain could be aggravated by the slightest movement during transfer, the resident reported that he/she was not in fear. There was no intentional harm or injury to the resident, and the allegation of abuse was unsubstantiated. Social services and the Psychiatric provider would follow up, as needed, for emotional support. Nurse aide staff would be reeducated on proper transfer techniques using mechanical lift, transferring a resident with chronic or acute pain, and customer service.</p> <p>A letter dated 10/17/24 identified that NA #3's employment was terminated as of 10/11/24.</p> <p>A letter dated 10/17/24 identified that NA #4's employment was terminated as of 10/11/24.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview with Resident #16 on 2/23/25 at 8:00 AM identified that he/she was able to recall the hoier transfer that took place on 10/3/24. Resident #16 identified that two of the nurse aides that were involved with that transfer were more than rude and did not know what they were doing while transferring him/her from the bed to the chair.</p> <p>Interview with NA #3 on 2/25/25 at 11:57 AM identified that on 10/3/24, another nurse aide, NA #4 had asked for assistance with providing care and transferring Resident #16. NA #3 told NA #4 that she was uncomfortable helping her because Resident #16 had told her that he/she wanted to see her suspended, but she would provide assistance but would remain quiet. NA #3 indicated that she had reported her concerns to the Administrator in the past. NA #3 identified that she greeted Resident #16 upon entering the room but otherwise remained quiet, when she and NA #4 turned Resident #16, the resident stated that she wanted to lose weight and buy more clothes. NA #3 identified that she told NA #4 that she had to assist another resident on her assignment, but Resident #16 indicated that he/she wanted to get up to his/her chair, so they called NA #2 to assist, and all 3 assisted with the hoier transfer. NA #3 indicated that after Resident #16 was transferred into the motorized wheelchair and properly positioned she left the room. NA #3 indicated that it was NA #4 that made a comment that Resident #16 had only thanked one of the nurse aides while all three had provided assistance. NA #3 identified that after this incident she was terminated and that nobody could tell her who or what was said to result in a termination.</p> <p>Interview with the DNS on 02/25/25 at 12:33 PM identified that she was not the DNS at the time of the incident, but it was disrespectful to laugh at a resident and to suggest that he/she should have thanked the staff members. The DNS further identified that this is the resident's home, and all residents were expected to be treated with dignity and respect, at all times.</p> <p>Although attempted, interviews with NA #2, NA #4 and RN # 6 were not obtained.</p> <p>The facility's Resident's Rights policy directs that residents have the right to be treated with consideration, respect, and full recognition of dignity and individuality.</p>