STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075144	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Guilford	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)
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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #17) reviewed for advance directive, the facility failed to ensure the resident or resident representatives wishes for an advance directive/code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops) were obtained and implemented. The findings include: Resident #17 was admitted to the facility in January 2021 with diagnoses that included dementia and Wernicke's encephalopathy. A Transfer Discharge Report dated 1/7/21 identified Resident #17 was transferred from another facility with a code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops) of full code (full code directs the medical team to take all possible measures to save the residents' life in the event of a medical emergency). The admission MDS dated [DATE] identified Resident #17 had moderately impaired cognition. A physician's order dated 5/20/21 directed the resident be full code. A resident care conference note, written by the MDS Coordinator, dated 1/11/22 at 12:30 PM identified a care conference was held with the resident in his/her room. A call was placed to the resident representative for update. MDS Coordinator requested a new signed advance directive consent form, because the DNR form was not found in the medical record and a new form to be signed was placed in the chart. A physician's order dated 3/4/22 directed Resident #17 be do not resuscitate (DNR). (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with RN #3 (day supervisor) on 2/23/25 at 9:50 AM indicated that when a resident is admitted , the RN supervisor is responsible, during that shift, to have the resident sign the advance directive, and the nurse signs as the witness. Further, if the resident is cognitively impaired and has a resident representative, the RN is responsible to call the resident representative and discuss advance directive wishes. RN #3 indicated the APRN, or physician is responsible to sign the advance directive consent form within 24 - 48 hours after admission once signed by the resident or representative. Review of Resident #17's advance directive consent form identified the resident representative's name was typed on the form, but the resident representative did not sign it. RN #3 noted in the progress note dated 1/11/22 there was a care conference that identified there was no an advance directive signed in the clinical record and staff would have to have the resident representative sign one. RN #3 indicated that there were no other notes identifying who attempted to contact the resident representative or inform him/her to come in and sign the advance directive form. RN #3 indicated that the form in the chart was not valid. Interview with the DNS and RN #7 on 2/25/25 at 6:51 AM indicated that it was the admitting nurses responsibility to complete an advance directive consent form at the time of admission. RN #7 indicated that if the resident representative comes in with the resident at time of admission, they sign it then if not then the charge nurse must call the resident representative and discuss their wishes for an advance directive. RN #7 indicated that if the nurse cannot reach the resident representative, then he or she must write a progress note and the next shift must attempt to call until the facility reaches the representative. Further, the advance directive was not found in overflow. Review of the Advance Directive Policy identified the facility provides the resident or residents representative, upon admission notice of the policy of advance directive and the resident's rights regarding refusal of treatment. Licensed nursing staff and/or attending physician will review the advance directive with the capable resident or the appropriate decision maker. The plan of care related to advance directive and withholding life sustaining treatment will be documented on the resident's advance directive consent form and the physician's orders. A physician progress note will address the advance directive and any decisions regarding refusal or withholding treatments. The consent form will be signed and dated by the resident or resident's representative, the physician, and the person (nurse) who explains the advance directive. A physician's order will be obtained regarding the advance directive. The Advance directive consent form will be kept in the resident's medical record. The residents' advance directive will be documented in the residents' care plan and will be reviewed on a quarterly basis and as needed for any changes.

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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** 42117 Based on review of the clinical record, facility policy, and interviews for 3 residents (Resident #16, 54, and 85) the facility failed to notify the physician and/or the resident representative with a change in condition. For Resident #16, reviewed for dignity, the facility failed to ensure the Psychiatric APRN was immediately notified when the resident that expressed suicidal ideation, for Resident #54, reviewed for nutrition, the facility failed to ensure the resident representative was notified of a weight loss and the implementation of a supplement, and for Resident #85, reviewed as a closed record, the facility failed to ensure the physician was notified following an unwitnessed fall. The findings include. 1. Resident #16 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder, mood disorder due to known physiological condition with mixed features, major depressive disorder, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #16 had intact cognition, had little interest or pleasure in doing things, felt down, depressed, or hopeless 2 - 6 (several) days, and felt social isolation often. The care plan dated 8/7/24 identified 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. The care plan 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. The care plan further identified Resident #16 was at risk for potential adverse effects of psychotropic drug use. Interventions included reporting any mood state/behavior changes to the physician or APRN, monitoring for a wide range of unpleasant side effects of antidepressants including but not limited to agitation, irritability, and anxiety and report to the physician or APRN, and monitoring his/her mental status functioning on an ongoing basis. The Social Services Assessment - Quarterly dated 10/22/24 identified Resident #16 reported feeling down, depressed, or hopeless, was having trouble falling asleep or staying asleep, feeling tired or having little energy, having a poor appetite or overeating, and having thoughts that he/she would be better off dead or harming oneself with a 2 - 6-day frequency of symptoms. The document's summary/review since last assessment identified Resident #16 remains long term with a DNR status, no signs or symptoms of distress or concerns notes. Resident #16 was encouraged to attend activities of his/her preference, psychosocial supports will be provided as needed and psychiatric services will be provided as needed for anxiety, depression, and PTSD. The Social Services note dated 10/22/24 at 5:54 PM identified that Resident #16 reported to the Social Service worker during the quarterly assessment that he/she did not feel suicidal today, but she does other days, this was reported to nursing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services noted dated 10/22/24 at 5:56 PM identified that the writer noted in the Psychiatric APRN referral book that Resident #16 feels suicidal at times. Review of the nurse's notes dated 10/22/24 through 10/23/24 failed to identify that the physician or APRN was immediately notified that Resident #16 verbalized feeling suicidal at times. The Psychiatric APRN note dated 10/24/24 at 1:50 PM identified that Resident #16 reported suicidal ideation (SI) to the social worker. Upon entering the room, the patient was calm, cooperative, and pleasant, and appeared surprised to hear the reason for our visit today. Resident #16 denied any active thoughts or plans of self-harm, and stated that he/she must have interpreted the social worker's question incorrectly, further explaining that he/she had thoughts of dying only in reference to his/her current medical condition and does not have thoughts of killing him/herself. Interview with APRN #2 on 2/25/25 at 9:53 AM identified that the facility's social worker identified the concern during Resident #16's quarterly social service assessment, and that when she went in to talk to Resident #16 a day or two later, the resident emphasized that any thoughts of death were due to his/her multiple comorbidities but was not feeling suicidal. APRN #2 indicated that if a resident makes a suicidal comment, it should be reported to the psychiatric provider right away, and that she would have expected to have been notified of Resident #16's comments of SI. APRN #2 indicated the SI should not have been documented in the Psychiatric APRN book. APRN #2 further indicated that if she wasn't in the building, at the time of the incident, she would have had a telework visit with Resident #16 to have a conversation about the statement that was made, determine a risk assessment, and then determine if Resident #16 needed to go the hospital or was safe to stay. APRN #2 identified that after the telehealth visit, she would have followed up in person if no risk of self-harm was identified, but if an immediate concern was identified, Resident #16 would have been placed on 1:1 supervision until he/she was transferred to the hospital. APRN #2 indicated that after her visit with Resident #16 there was no need for 1:1 supervision or transfer to a higher level of care. Interview with SW #1 on 2/25/25 at 11:05 AM identified that she remembered completing Resident #16's quarterly assessment, but she could not recall exactly what was said. SW #1 indicated that Resident #16 reported suicidal ideation, in the past, and that it had been a long time since he/she had any thoughts of suicide. SW #1 could not recall the timeline for when Resident #16 had thoughts of suicide, but she did not feel like it was recent. SW #1 indicated that after she completed Resident #16's quarterly assessment, she notified the nursing staff that Resident #16 was having those thoughts in the past, but SW #1 was unable to recall which nurses she had spoken with. SW #1 indicated that she could not recall what she discussed with the nursing staff, but that after speaking with the nursing staff, she felt that adding Resident #16 to the Psychiatric APRN book instead of calling the APRN, was appropriate because she did not feel like Resident #16 was in imminent danger, as the SI was not current and she felt like Resident #16 was safe. In an interview with the DNS and the [NAME] President of Clinical Operations (RN #2) on 2/25/25 at 12:33 PM, the DNS identified that the facility does not have a policy on suicidal ideation. The DNS further identified that she would have expected a suicide risk assessment to have been completed at the time of Resident #16's comments of feeling suicidal. RN #2 indicated that he would have expected the social worker to have obtained more information to figure out when the suicidal ideation had occurred, and he also would have expected the nurse to notify the provider. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Change in Resident Condition/Family/MD Notification policy directs a significant change in the condition of the resident's physical, mental, or emotional status, or in the event of an accident involving the resident, will be reported to the physician and family. 2. Resident #54 was admitted to the facility in March 2022 with diagnoses that included dementia. The weight record summary dated 10/5/24 identified Resident #54 weighted 102.0 lbs. The quarterly MDS dated [DATE] identified Resident #54 had severely impaired cognition, required total assistance for eating and had no known weight loss in the last month or 6 months. The dietitian progress note dated 10/9/24 identified Resident #54 was on a puree diet with a house supplement of 4 oz twice a day. Resident #54 required total assistance to be fed meals. Residents #54's current weight is 101.1 lbs., and the ideal body weight is 110 lbs. plus or minus 10%. The care plan dated 10/24/24 identified Resident #54 had the potential for a nutritional decline related to dementia and a history of weight loss. Interventions included providing diet and supplements as ordered, weights as ordered, encourage fluids, assist with meals as needed and watch for signs of aspiration. The weight record summary dated 11/7/24 identified Resident #54 weighed 99.2 lbs., a 2.8 lbs. weight loss. A physician's monthly order dated November 2024 directed to provide a puree diet with thin liquids and house supplement 4 ounces twice a day. The weight record summary dated 12/1/24 identified Resident #54 weighed 95.0 lbs., a 4.2 lbs. weight loss. The dietitian progress note dated 12/4/2024 at 6:14 AM noted Resident #54 weight was 94 lbs. on 12/1/24. This reflects a 7.2% weight loss over the past month. Resident #54 is tolerating his/her meals with variable intake but needs assistance at mealtime. No therapeutic diet restrictions in place. House supplement 4 oz twice a day for increased calories offered. Continue to encourage food/fluids as able. Review of the clinical record failed to reflect the resident representative had been notified of the weight loss or the increase in the house supplements. The APRN progress note dated 12/5/24 by APRN #1 (placed in the medical record after surveyor inquiry on 2/25/25 at 10:06 AM) identified Resident #54 was seen for a weight loss of 5 lbs. in 1 month. Resident #54 has advanced dementia. The plan is to recheck weight and ordered labs. The weight record summary dated 12/6/24 identified Resident #54 weighed 93.0 lbs. The weight record summary dated 12/7/24 identified Resident #54 weighed 93.4 lbs. A physician's order dated 12/9/24 directed to give house supplement 4 ounces three times a day. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dietitian progress note dated 12/11/24 at 11:39 AM identified Resident #54's weight was 93.4 lbs. on 12/7/24. Resident #54 needs assistance/encouragement with meals. House supplement in place to help meet needs. The dietitian progress note dated 12/19/24 at 6:46 AM identified the house supplement increased to three times a day to help meet needs. The annual MDS dated [DATE] identified Resident#54 had an unplanned weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Interview with the DNS on 2/25/25 at 7:10 AM identified the charge nurse was responsible to notify the resident representative of the weight loss when it was identified and to notify the resident representative of the new order for supplements on 12/9/24. Interview with the Dietitian on 2/25/25 at 7:15 AM he indicated that he has a communication book for nursing to notify him of a resident's weight loss. The Dietitian indicated that all residents are weighed in the first 10 days of a month. The Dietitian indicated that all reweights are due by the 15th of the month if noted to have a 5% weight loss or gain. The Dietitian indicated that it was the charge nurse's responsibility to determine if there was a 5% difference and have the nurse's aide get another weight. The Dietitian indicated that he is in the facility 2 days a week every Thursday and Friday. The Dietitian indicated that if a weight loss is noted on a Saturday it will go into his communication book, and he will see it on Thursday when he comes into the facility. The Dietitian noted if he identifies a resident has had a weight loss, he will write it in the APRN's communication book with any recommendations so she will see it the next time she is in the facility. The Dietitian indicated that the nurse was responsible to notify the resident representative of the weight loss and the increase in the supplements. The interview with APRN #1 on 2/25/25 at 10:00 AM indicated she had seen Resident #54 for a weight loss but does not recall the date. APRN #1 indicated that she documents in a different system and her notes are not in the resident's electronic medical record. APRN #1 indicated that she will transfer her notes over now. Interview with APRN #1 on 2/25/25 at 10:27 AM indicated she had seen Resident #54 on 12/5/24 for the weight loss of 5 lbs. in a month and placed Resident #54 on weekly weights for 4 weeks and ordered labs. APRN #1 indicated that she had seen Resident #54 on 12/19/24 for follow up and the labs that were within normal limits and the resident was stable from the last visit on 12/5/24. Review of the clinical record identified the weekly weights were not documented on 12/13/24, 12/20/24, and 1/3/25. Interview and review of the clinical record with DNS on 2/25/25 at 10:40 AM failed to reflect the resident representative was updated with the weight loss and the new physician order to increase the house supplements. Review of the Weight Monitoring Policy identified weights will be taken and recorded on the weight sheet in the EMR. If there is a 5 lb. weight discrepancy plus or minus a reweight should be obtained. The charge nurse should review then weight and compare this to the previous weights to determine a 5% weight change in 30 days or a 10% weight change in 180 days. Significant weight changes will be reported to the physician or APRN, resident representative, and dietitian. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Change in Resident Condition Notification to Physician and Resident Representative identified all significant changes in resident's condition will be reported to the physician and resident representative. The nurse will document in the nurses notes that the physician and resident representative have been notified of the change in condition. 3. Resident #85 was admitted to the facility in November 2018 with diagnoses that included ataxic cerebral palsy, epilepsy, and history of falling. The quarterly MDS dated [DATE] identified Resident #85 had intact cognition, was always continent of bowel, frequently incontinent of bladder, required partial staff assistance with toileting and bathing, and supervision with transfers. The care plan dated 11/28/24 identified Resident #85 had a history of falls. Interventions included to notify the physician of pain, bruising, and to complete neurological checks per protocol. Review of the clinical record identified Resident #85 had unwitnessed falls on 12/22/24 and 12/26/24. A reportable event form dated 12/27/24 identified Resident #85 had a fall at 10:00 PM on that date. The form, signed as completed by RN #6, identified an on call provider was notified of the fall, however, the form failed to identify the provider's name, title or when the notification was made. A nurse's note dated 12/27/24 at 10:03 PM by RN #6 identified Resident #85 had an unwitnessed fall. The note identified Resident #85 was observed on the floor sitting on his/her buttocks and that Resident #85 reported falling after an attempt to self transfer. The note further identified Resident #85 sustained a linear scratch to the back of the right buttock, a superficial abrasion to the right top of the thigh measuring 15.5 inches in length, and a bruise above the left elbow measuring 6 cm x 5 cm. The note also identified RN #6 attempted to reach the on call provider regarding the fall but was unsuccessful. A change of condition assessment dated [DATE] at 10:26 PM completed by RN #6 identified no provider notification was done. Further review of the clinical record failed to identify documentation of additional attempts to notify Resident #85's physician of the fall on 12/27/24 at 10:00 PM. A change of condition assessment note dated 12/28/24 at 11:54 AM by RN #3 identified Resident #85 had altered mental status which included sleepiness and lethargy, right lower extremity redness and warmth, and complaints of left hip pain. The note identified the on call provider was notified and Resident #85 was sent to the hospital for evaluation of increased lethargy, left hip pain, and bilateral pitting edema with right lower extremity redness and warmth. (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 2/25/25 at 12:30 PM identified that the facility policy directs that when a resident has any change of condition, which includes falls, the nurse assigned to the resident or the RN supervisor should make attempts to contact the on call provider. The DNS identified if the on call provider is unable to be reached, the nurse should then contact the medical director. The DNS identified that RN #6 should have made attempts to contact the medical director following the failed attempts to reach the on call provider, especially given that Resident #85 sustained some injuries with the fall and Resident #85's history of recent multiple falls within a 4 day period. Although attempted, an interview with RN #3 and RN #6 was not obtained. The facility policy on change of condition directs that the resident's attending physician or covering provider would be notified of any significant change of condition or accident involving the resident. The policy further directs if the physician or covering provider were not available, the medical director would be called and notification would be documented in the clinical record. 46040 47457

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 7 residents (Resident #33) reviewed for pre-admission screening and resident review (PASARR), the facility failed to notify the State-designated authority when the resident received a new psychiatric diagnosis. The findings include: Resident #33 was admitted to the facility in May 2019 with diagnoses that included Parkinson's disease, depression, anxiety, and repeated falls. The Admission PASARR dated 5/1/19 determination date 5/30/19 identified Resident #33 had no major mental disorder, did not have dementia, Alzheimer's, or psychotic/delusional disorder. The outcome was Resident #33 was approved for long term care for skilled nursing care. Resident #33 is reported to be occasionally disoriented in situations, with deficits noted in memory and judgment at this time. The quarterly MDS dated [DATE] identified Resident #33 had severely impaired cognition, and a diagnosis of depression and anxiety. The MDS did not reflect a diagnosis of psychotic disorder. A psychiatric note dated 10/17/22 identified Resident #33 had mild paranoia. Resident #33 has depression, psychosis, confusion, and memory impairment. Assessment and plan delusional disorder, resident continues with delusions and paranoia and depression due to overall decline. Resident recently trialed on Seroquel due to worsening signs and symptoms of psychosis. The staff report Resident #33 has been more pleasant. Resident #33 appears to be improving on Seroquel and will continue medication. Diagnosis of depression and psychotic disorder with delusions. The quarterly MDS dated [DATE] identified Resident #33 had severely impaired cognition, short and long-term memory problems, and a diagnosis of anxiety and depression. but did not reflect psychotic disorder. The MDS did not reflect a diagnosis of psychotic disorder. The care plan dated 10/26/22 failed to reflect the diagnosis of psychotic disorder. Review of the Diagnosis Record identified Resident #33 had a diagnosis of psychotic disorder with delusions dated 1/30/23. The quarterly MDS dated [DATE] identified Resident #33 had severely impaired cognition, and a diagnosis of anxiety, depression, and psychotic disorder. A physician's order dated 10/25/23 directed to administer Pimavanserin Tartrate (antipsychotic) 34mg once daily and Seroquel (antipsychotic) 25mg daily at bedtime. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 2/25/25 at 8:54 AM indicated she is responsible to update State-designated authority when a resident receives a new psychiatric diagnosis. SW #1 it was the psychiatric providers responsibility to inform the social worker when they give a resident a new psychiatric diagnosis. After clinical record review, SW #1 indicated that Resident #33 received the new diagnosis of psychotic disorder with delusions on 1/30/23. SW #1 indicated that she will submit a new Level 1 to determine if a Level 2 is needed. Interview with APRN #2 (psychiatric APRN) on 2/25/25 at 11:02 AM indicated that she reviewed the clinical record and identified the first psychiatric note that adds the diagnosis of psychotic disorder with delusions was dated 10/17/22 after being trialed on Seroquel. Review of the Preadmission Screening and Resident Review PASARR identified PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for short/long term care. All applications to a Medicare/Medicaid certified nursing facility are evaluated for mental illness and/or intellectual disabilities to ensure they are placed in the appropriate setting and receive the services they need in the nursing home setting. The state agency does the reviewing of PASARR level 1 screens and level of care for individuals who are Medicaid active, eligible, or pending. Conducting a level 2 evaluations for person known or suspected of having serious mental illness that are residing in or applying to a Medicaid Certified nursing facility. All admissions will have an approved PASARR. A level 1 preliminary assessment screens are done to determine if there is mental illness or mental retardation. Those individuals that test positive for level 1 are then evaluated in depth with a level 2 PASARR. All positive level 2 outcomes will have a care plan created.

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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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 residents (Resident #33, 45, 70 and 85) the facility failed to provide care in accordance with professional standards of practice. For 3 of 3 residents, (Resident #33, 45 and 85), reviewed for accidents, the facility failed to ensure neurological assessments were completed according to the facility policy after the residents fell either without a witness or had a head strike, and for 1 of 6 residents (Resident #70) who were at risk for the development of pressure ulcers, the facility failed to ensure the LAL (low air loss) mattress was set according to the manufacturer recommendations, and failed to ensure the Braden Scale and the weekly body audits were completed per facility policy. The findings include: 1. Resident #33 was admitted to the facility in May 2019 with diagnoses that included Parkinson's disease, psychotic disorder with delusions and hallucinations, and repeated falls. A physician's order dated 7/12/24 directed the resident needed assistance of 1 person with a rolling walker for mobility and transfers. The care plan dated 7/16/24 identified Resident #33 was at risk for falls. Interventions included pain management review, a nightlight for adequate light at night, and to declutter the room. The quarterly MDS dated [DATE] identified Resident #33 had moderately impaired cognition, required maximum assistance with toileting, needed moderate assistance to ambulate 50 feet, and has had 2 or more falls with no injury and 2 or more falls with minor injuries such as skin tears or bruises since the prior assessment. a. A Reportable Event Form dated 9/24/24 at 4:30 PM identified Resident #33 was in his/her room picking up dirty clothes at the bottom of the closet when he/she slipped out of the wheelchair and onto the floor. No injuries were noted. Interview with the DNS on 2/25/25 at 9:59 AM identified after a resident has fallen an RN must do the assessment first before moving the resident. The DNS indicated that at the time of this fall Resident #33 had moderately impaired cognition and that the neurological assessment would have to be completed per the facility policy because a staff person did not witness the fall. The DNS indicated that the expectation was that the nurses would follow the neurological assessment policy and reviewing the accident and incident report the neurological assessments were not complete. b. A Reportable Event Form dated 10/11/24 at 11:15 AM identified Resident #33 was found on the floor in front of the recliner chair at the bedside. No injuries noted. Resident #33 indicated that he/she was reaching for the garbage can and slid off the recliner chair. The nurse's note dated 10/11/24 at 1:45 PM identified Resident #33 was found on the floor in front of his/her recliner chair. Neurological assessment within normal limits and initiated post fall vital signs and neurological checks and monitoring for 72 hours. (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 Neurological checks form dated 10/11/24 at 1:45 PM identified the neurological assessment would include blood pressure, pulse, respirations, resident's level of consciousness, bilateral pupils if reactive or not, and strength of right and left extremities. The form required the neurological assessment to be completed every 15 minutes for the first hour after the fall, then every hour for 4 hours, every 4 hours for the next 24 hours, and every shift for 48 hours after that. The form identified the assessments were completed 6 out of the 20 required times. Staff did not complete 14 required neurological assessments. The interview with the DNS on 2/25/25 at 10:02 AM indicated that on 10/11/24 there was an unwitnessed fall, and the neurological assessment were started but not completed. The DNS indicated that the expectation was that the nurses would follow the neurological assessment policy and would have completed the assessments. c. A Reportable Event Form dated 12/1/24 at 6:30 PM identified Resident #33 was trying to get a hairbrush out from under the bed and slid out of the recliner chair. Resident #3 was noted to have a left knee abrasion, right knee discoloration, and right shoulder pain. The intervention was to educate the resident to call for assistance and staff not to use chuck pads on recliner. Review of the Neurological Checks form dated 12/1/24 at 6:30 PM identified 13 required neurological checks were not completed per the policy. Interview with the DNS on 2/25/25 9:59 AM identified for the unwitnessed fall on 12/1/24 the neurological assessments were started but not completed. The DNS indicated she would have expected them to be completed per policy. Interview with the DNS on 02/25/25 at 10:15 AM indicated that the expectation was the nurses would follow the neurological assessment policy after an unwitnessed fall with a resident that had moderately impaired cognition. The facility's Neurological Checks policy directs neurological checks to be instituted as a nursing measure following a head injury, TIA and seizure disorder. A neurological check flow sheet will be instituted by the nurse and shall include date and time of the assessment, level on consciousness, pupillary response, strength and sensation of the extremities, and vital signs. The checks will be completed as follows: a. Every 15 minutes for the first hour. b. Every hour for 4 hours. c. Every 4 hours for the next 24 hours. d. Every shift for 48 hours. 2. Resident #45 was admitted to the facility on [DATE] with diagnoses that included dementia, post-traumatic stress disorder, and history of falls. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual MDS dated [DATE] identified Resident #45 had moderately impaired cognition, required setup assistance (helper assists only prior to or following an activity) with sitting to standing and walking 50 feet with two turns, was independent walking 10 feet, and had sustained two falls with no injury, two falls with injury, and no falls with major injury since the prior assessment. The care plan dated 5/22/24 identified Resident #45 required assistance with all ADL's and was non-adherent with assistance, at times. Interventions included assisting with transfers out of bed per the physician's order. Resident #45 was at risk of bruising and bleeding due to the use of anticoagulation medication. Interventions included reminding Resident #45 to use caution and to be aware of extremity positioning when transferring and ambulating. The care plan further identified Resident #45 was at risk for falls due to muscle weakness, dementia, and psychotropic medications, and was not adherent with transfer orders at times, increasing the risk for falls. Interventions included keeping commonly used articles within easy reach, offering music at bedtime to provide a soothing environment, and providing a well-lit, clutter free environment. The nurse's note dated 5/30/24 at 7:49 PM identified that Resident #45 sustained a witnessed fall at 8:25 PM; resident fell on buttocks and hit his/her head, denied headache, no visual disturbances at this time. Resident complained of right clavicle pain, no bruising, no abrasions, no lacerations, or skin tears were observed at this time. No external rotation observed to bilateral lower extremities; no unilateral lengthening observed to lower extremities. Resident is alert and oriented times 2 stated that he/she was trying to walk and fell ; the fall was witnessed by charge nurse who was in the room but wasn't able to get to the resident quick enough to prevent the fall. Resident observed to perform independent transfer from bed took a few steps toward the restroom without walker and fell ; the walker was observed near the window. Staff were educated to keep walker near the resident and within reach at all times. The resident was assisted back to bed, Tylenol was given for the complaint of pain, neurological checks were initiated per facility policy, and resident's family and on call APRN were notified with no new orders. The Reportable Event Form dated 5/30/24 identified Resident #45 had a witnessed fall at 8:25 PM in the bedroom. Resident #45 had gotten out of bed without assistance, took a few steps towards the bathroom, and fell on his/her buttocks, hitting the back of his/her head on the wall. Description of actions taken included neurological checks and vital sign monitoring per facility's protocol, Xray to the right clavicle, pain evaluation and management, change in activity status, PT/OT evaluation, sling to the right upper extremity, and orthopedic, psychiatry, and social services follow-up. Review of the facility's Accident and Investigation documentation and Resident #45's clinical record failed to identify documentation that neurological assessments were completed, per the facility's policy, following the witnessed fall with a head strike, on 5/30/24. Interview with the DNS on 02/25/25 at 8:44 AM identified that while she was not the DNS at the time of the incident, she would have expected neurological assessments to be completed by the charge nurse for 72 hours, per the facility policy, following a fall resulting in the resident hitting his/her head. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Neurological Checks policy directs neurological checks to be instituted as a nursing measure following a head injury, TIA and seizure disorder. A neurological check flow sheet will be instituted by the nurse and shall include date and time of the assessment, level on consciousness, pupillary response, strength and sensation of the extremities, and vital signs. The checks will be completed as follows: a. Every 15 minutes for the first hour. b. Every hour for 4 hours. c. Every 4 hours for the next 24 hours. d. Every shift for 48 hours. The facility's Falls: Minimizing Risk of Injury policy directs that a status post-Accident and Incident (A&I) report will be completed and an interdisciplinary fall assessment in order to identify the potential causes of the fall. A status post A&I assessment and neurological checks will be completed on any resident that experiences an unwitnessed fall and is unable to accurately verbalize if he/she hit their head due to cognitive status or experienced any type of head injury. The post A&I assessment and neurological monitoring will be documented for 72 hours. 3. Resident #85 was admitted to the facility on [DATE] with diagnoses that included ataxic cerebral palsy, epilepsy, and history of falling. The quarterly MDS dated [DATE] identified Resident #85 had intact cognition, was always continent of bowel, frequently incontinent of bladder, required partial staff assistance with toileting and bathing, and supervision with transfers. The care plan dated 11/28/24 identified Resident #85 had a history of falls. Interventions included to notify the physician of pain and bruising, and to complete neurological checks per protocol. Review of the clinical record identified Resident #85 had unwitnessed fall on 12/22/24. A reportable event form dated 12/26/24 identified Resident #85 had a fall at 9:15 PM on that date. Resident #85 reported attempting to ambulate to the bathroom, losing balance, and falling but denied a head strike. The form was signed as completed by RN #6. A change of condition assessment note completed by RN #6 on 12/26/24 at 10:21 PM identified that Resident #85 had an unwitnessed fall with no injuries and denied a head strike. The note further identified that the on-call provider was notified, and treatment orders included to start neurological checks. Review of the clinical record failed to identify any post accident/incident assessment documentation related to Resident #85's fall on 12/26/24. Review of a neurological check documentation flowsheet dated 12/26/24 identified neurological checks were initiated at 9:15 PM. Further review identified neurological checks were completed for the following dates and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/26/24 at 9:30 PM. 12/26/24 at 9:45 PM. 12/26/24 at 10:00 PM (15 minutes x 4). 12/26/24 at 11:00 PM. 12/27/24 at 12:00 AM. 12/27/24 at 1:00 AM. 12/27/24 at 2:00 AM (every hour x 4). 12/27/24 at 6:00 AM. 12/27/24 at 10:00 AM. 12/27/24 at 1:00 PM. 12/27/24 at 5:00 PM. 12/27/24 at 9:00 PM (every 4 hours x 5). A reportable event form dated 12/27/24 identified Resident #85 had a fall at 10:00 PM on that date. A nurse's note dated 12/27/24 at 10:03 PM by RN #6 identified Resident #85 had an unwitnessed fall. The note identified Resident #85 was observed on the floor sitting on his/her buttocks and that Resident #85 reported falling after an attempt to self-transfer. The note further identified Resident #85 sustained a linear scratch to the back of the right buttock, a superficial abrasion to the right top of the thigh measuring 15.5 inches in length, and a bruise above the left elbow measuring 6.0 cm x 5.0 cm. The note also identified RN #6 attempted to reach the on call provider regarding the fall but was unsuccessful. Review of the clinical record failed to identify any post accident/incident (A&I) assessments were initiated or that any neurological monitoring was initiated following the 12/27/24 fall at 10:00 PM. Review of a neurological check documentation flowsheet dated 12/26/24 identified a neurological check completed on 12/28/24 at 1:00 AM, approximately 3 hours after Resident #85's most recent fall on 12/27/24 at 10:00 PM. No other neurological checks were documented, with a handwritten note MLOA (medical leave of absence) written in the 12/28/24 3:00 PM - 11:00 PM shift assessment area. A change of condition assessment note completed by RN #3 on 12/28/24 at 11:54 AM, 13 hours after the fall, identified Resident #85 had altered mental status which included sleepiness and lethargy, right lower extremity redness and warmth, and complaints of left hip pain. The note identified the on-call provider was notified and Resident #85 was sent to the hospital for evaluation of increased lethargy, left hip pain, and bilateral pitting edema with right lower extremity redness and warmth. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 2/25/25 at 12:30 PM identified that Resident #85 should have had post A&I assessments completed following the 12/26/24 unwitnessed fall, and that neurological checks should have been completed following the 12/27/24 unwitnessed fall, especially due to Resident #85's history of epilepsy and multiple recent falls. The DNS identified that neurological checks should have been reinitiated beginning at every 15 minutes per the facility policy following the 12/27/24 fall and that post A& I assessments should have been done every shift following each fall and documented on the forms for each. The DNS identified that she was aware there was an issue related to neurological checks being completed and was developing a plan to educate the nursing staff. Although attempted, an interview with RN #3 and RN #6 was not obtained. The neurological check documentation form directed that neurological checks were to be done following a head injury, unwitnessed fall, seizure disorder, and any situation that may alter neurological status. The facility neurological check policy key, included on the form, directed vital signs and neurological checks to be done every 15 minutes for the first hour, every hour for 4 hours, every 4 hours for 24 hours, and every shift for 48 hours. The post A&I assessment form directed that the form should be completed every shift for 72 hours following an accident or incident, and the physician should be notified for any new or worsening symptoms. The facility policy on falls directed that any resident who experienced an unwitnessed fall and is unable to accurately verbalize if he/she hit their head due to cognitive status or experienced any kind of head injury would have post fall A&I assessments and neurological monitoring completed for 72 hours. 4a. Resident #70 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy and dementia. Braden Scale dated 8/14/24 identified Resident #70 was at moderate risk of developing a pressure ulcer. The quarterly MDS dated [DATE] identified Resident #70 had moderately impaired cognition, was always incontinent of bowel and bladder and was totally dependent for bed mobility, eating, toileting, bathing, dressing, transfers, and personal hygiene. Additionally, Resident #70 was at risk for developing a pressure ulcer, but did not have a pressure ulcer on admission. A physician's order dated 8/14/24 directed to complete a Braden Scale (Braden Scale is a tool used to assess a resident's risk of developing a pressure ulcer) on admission and every week for 4 weeks on Saturday during the 7:00 AM to 3:00 PM shift. Braden Scale due the week of 8/24/24 was not completed. Braden Scale dated 8/31/24 identified Resident #70 was at mild risk of developing a pressure ulcer. Braden Scale dated 9/7/24 identified Resident #70 was at moderate risk of developing a pressure ulcer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 9/11/24 identified Resident #70 was at risk for skin breakdown. Interventions included Braden Scale as per facility protocol. Braden Scale due the week of 9/14/24 was not completed. Interview with the DNS on 2/24/25 at 10:00 AM identified when a resident is admitted to the facility, the Braden Scale is to be done on admission and weekly for 4 weeks following admission and then quarterly. After review of the clinical record, the DNS indicated that staff did not complete a Braden Scale the weeks of 8/24/24 or 9/14/24 per the physician order. b. A physician's order dated 8/16/24 directed licensed staff to complete a body audit on admission and weekly thereafter. Review of the clinical record dated 8/14/24 to 2/24/25, 27 weeks, identified a weekly body audit was not completed 9 times, on 8/23/24, 9/6/24, 9/13/24, 9/20/24, 10/25/24, 12/13/24, 1/17/25, 1/31/25, and 2/21/25. Interview with the DNS on 2/24/25 at 10:00 AM identified that staff complete a body audit on residents' admission, readmission, and weekly based on their shower schedule. The DNS a physician's order will indicate when a resident is to have the weekly body audit and what shift. The DNS indicated that the body audits are to be completed weekly by the charge nurses to identify any new skin issues on a resident and the charge nurses are responsible to fill out the body audit form each week. After clinical record review, the DNS indicated that not all of the weekly body audits had been completed between August 2024 to current. c. The quarterly MDS dated [DATE] identified Resident #70 had severely impaired cognition, was always incontinent of bowel and bladder and was totally dependent for bed mobility, eating, toileting, bathing, dressing, transfers, and personal hygiene. Additionally, Resident #70 was at risk for developing a pressure ulcer, but did not have a pressure ulcer. The care plan dated 12/27/24 identified Resident #70 has impaired cognition and was on hospice services. Hospice to provide mattress. A Weight Report Summary dated 2/7/25 identified Resident #70 weighed 100.0 lbs. A Weight Report Summary dated 2/18/25 identified Resident #70 weighed 110.0 lbs. Observation on 2/23/25 at 9:40 AM and 2:00 PM identified Resident #70 was lying in bed on a Low Air Loss (LAL) mattress which was set at 210 lbs., 100 lbs. more than the resident's 2/18/25 weight. Observation of the LAL mattress pump identified the dial starts at 50 lbs. and increases in increments of 30 lbs. until the maximum weight of 350 lbs. There is also an on/off switch and a switch for static on/off. Observation on 2/24/25 at 7:31 AM identified Resident #70 was lying in bed on the LAL mattress which was set at 210 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #2 (Corporate [NAME] President Clinical Operations) on 2/24/25 at 9:30 AM identified that the facility uses 2 primary LAL mattresses and based on manufacturer booklets the air mattresses were to be set to the resident's weight. RN #2 indicated that he would provide the manufacturer booklets. Interview with RN #9 (Vice President of Clinical Operations) on 2/24/25 at 10:43 AM indicated that within the last one hour, she went around to the LAL mattresses in the facility and set the pump dials to the resident's weights and placed duct tape over the dial so no one would be able to change the dial setting. RN #9 indicated that Resident #70 did not have duct tape because she was not aware Resident #70 was on a LAL mattress. Interview with RN #1 (Wound Nurse) with RN #9 (Vice President of Clinical Operations) present on 2/24/25 at 10:44 AM identified RN #1 was responsible to have a list of residents who have a LAL mattress and why the resident has the LAL mattress, however, RN #1 was unable to provide the list. RN #1 indicated that all residents on a LAL mattress will have a physician's order directing the resident is on the LAL mattress and directing to set the mattress to comfort, not weight. RN #1 indicated that Resident #70 was on a LAL mattress because he/she was on hospice. RN #1 indicated that for all LAL mattresses, he puts in the physician's orders, and all are set to comfort. After clinical record review, RN #1 identified there was not a physician's order for the LAL mattress. RN #1 was not able to identify when the LAL mattress was placed on Resident #70's bed. RN #1 identified he would put the order in today for a LAL mattress for Resident #70's and indicated it would be set for comfort. RN #1 indicated that he did not have the manufacturer books for the LAL mattresses that were in the facility. Interview with RN #4 (Hospice Case Manager) on 2/24/25 at 2:06 PM indicated hospice ordered the LAL mattress on 9/17/24 and it was delivered on 9/18/24. RN #4 indicated that the hospice nurse ordered the air mattress because Resident #70 was at risk for skin breakdown, had boggy heels staged as deep tissue injuries and would need relief from pressure due to the difficulty in repositioning him/herself. RN #4 indicated that Resident #70 was not cognitively intact and would not be able to verbalize if the LAL mattress was too hard or too soft. RN #4 indicated that the LAL mattress was to be set at the Resident #70's weight and the staff at the facility were informed of that when Resident #70 received the mattress. RN #4 indicated that if the LAL mattress was set higher than the resident's weight the LAL mattress would not be effective in pressure relief and would put the resident at greater risk of skin breakdown. RN #4 indicated that the physician order should be set per Residents #70's weight and not for comfort because Resident #70 cannot tell you if he/she is comfortable. Interview with the Wound APRN (APRN #3) on 2/25/25 at 9:20 AM identified that LAL mattresses should be used as part of the treatment plan for pressure ulcers, by helping to off-load (reduce pressure) an affected area. APRN #3 indicated that LAL mattresses should be set to a resident's weight, and an order to set a LAL mattress to comfort should be reserved for resident's receiving palliative care or Comfort Measures Only (CMO). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Wound Nurse (RN #1) on 2/25/25 at 9:18 AM identified the prior Interim DNS instructed him to set everyone's LAL mattress to comfort. Further, RN #1 identified that for all LAL mattresses, the physician's orders direct to set the mattresses to comfort. RN #1 could not recall the time that the directive from the Interim DNS was given, but he was told to in-service the nursing staff to use the resident's weight as a jumping off point and adjust the setting to the resident's preference/comfort. RN #1 further indicated that resident's mattress comfortability was assessed every shift; alert and oriented residents were asked by nursing staff about the comfort level of their mattress and residents who had impaired cognition were assessed for non-verbal cues for pain. Interview with APRN #1 on 2/25/25 at 9:25 AM identified that she was unaware that all residents with a LAL mattress had a standard order to set to the mattress to comfort, as the Wound Care Team typically places those orders. APRN #1 indicated that LAL mattresses were designed to be set to the resident's weight and that is the standard practice. APRN #1 identified that LAL mattresses require an order from the medical provider and are used as an intervention for residents with pressure ulcers or for residents at high risk for developing a pressure ulcer. Interview with the DNS on 2/25/25 at 12:53 PM identified that all LAL mattress orders should not be set to comfort. The DNS indicated that the orders should be set to the resident's weight, but the orders should also be looked at individually and take into account the resident's comfort. Review of the Wound and Skin Care Protocols identified the purpose was to prevent pressure ulcer formation by identifying those residents who are at risk for pressure ulcers and to develop appropriate interventions. All residents will be assessed by the nurse for risk of skin breakdown, utilizing the Braden Scale upon admission, readmission and every week for the first 4 weeks. Weekly body audits will be completed on shower day by a licensed nurse and all skin areas will have weekly documentation until healed. The Med-Aire Melody Alternating Pressure Low Air Loss Mattresses Replacement System Operators' Manual directs the control unit to be set to the patient's determined weight. The [NAME] Relief Alternating Pressure System with Low Air Loss Operation Manual directs to set the weight button according to the patient's weight and adjust the weight setting if the mattrass is too soft or firm to suit each patient's needs. 46040 47457

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #14) who were at risk to develop a pressure ulcer, the facility failed to ensure the Braden Scale and the weekly body audits were done per the physician's order and failed to ensure the LAL (low air loss) mattress was set per the manufacturer recommendations. The findings include: Resident #14 was readmitted to the facility on [DATE] with diagnoses that included fibromyalgia, delirium, and stroke. The admission nursing assessment dated [DATE] identified Resident #14 was noted to have an open area to the top of the coccyx that measured 3.0cm by 3.0cm by 2.0 with a 2.25 cm depth. Further, the assessment indicated the resident had a urinary catheter. A physician's order dated 5/27/23 directed to complete a Braden Scale on admission and every week for 4 weeks. The care plan dated 6/13/23 identified Resident #14 had a stage III pressure injury to the sacrum. Interventions included to assess the resident's risk of skin breakdown using the Braden Scale per policy, checking skin at least weekly on scheduled bath day, and use of a LAL mattress per physician orders. The quarterly MDS dated [DATE] identified Resident #14 had intact cognition and required total assistance with toileting, and extensive assistance with bed mobility, transfers, and dressing. Further, the MDS identified Resident #14 was at risk for pressure ulcers and had one stage III pressure ulcer of the sacral region. a. Review of the clinical record identified the Braden Scale was completed on admission 5/27/23 with a score of 17 which indicated the resident was at risk for pressure ulcer development. Further review identified the Braden Scale was not documented weekly for 4 weeks on 6/3/23, 6/10/23, 6/17/23 or 6/24/23. Facility documentation indicated Resident #14 was transferred to the hospital and returned to the facility on [DATE]. The hospital discharge summary dated 2/6/25 identified Resident #14 was hospitalized for a urinary tract infection and dehydration. The readmission nursing assessment dated [DATE] identified the Braden Score identified the resident was a mild risk for pressure ulcer development. Further review of the clinical record identified the weekly Braden Scale was not completed on 2/13/25 and 2/20/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 2/24/25 at 10:00 AM identified when a resident is admitted or a readmitted , the Braden Scale is to be done on admission or readmission and then weekly for 4 weeks and quarterly thereafter. After clinical record review, the DNS indicated that staff had not completed a Braden Scale following the readmissions on 5/27/23 and 2/6/25 per the physician order. Interview with RN #7 (Corporate Clinical Nurse) on 2/24/25 at 10:08 AM identified the Braden Scale was to be documented on admission within the admission assessment then weekly for 4 weeks and quarterly thereafter documented on the Braden Scale form. b. Physician's monthly orders for September 2024 (original order date 10/19/23) directed to complete a body audit, using the body audit form, on admission and every week by a licensed nurse on Mondays during the 7:00 AM to 3:00 PM shift. Review of the body audit forms dated 9/22/24 to 2/1/25 identified body audits were not done on 9/23/24, 9/30/24, 10/14/24, 10/21/24, 12/9/24, 12/30/24, 1/20/25, and 1/27/25, 8 out of 19 weeks. Interview with the DNS on 2/24/25 at 10:00 AM identified that residents have a body audit on admission, readmission, and weekly based on their shower schedule and time. The DNS indicated there is a physician's order that indicates when a resident is to have the weekly body audit and what shift. The DNS indicated that the body audits are to be completed weekly by the charge nurses to identify any new skin issues on a resident. The DNS indicated that the charge nurses are responsible to fill out the body audit form each week. After clinical record review, the DNS indicated that weekly body audits were not documented consistently from 9/1/24 to current. Interview with RN #7 (Corporate Clinical Nurse) on 2/24/25 at 10:08 AM identified that approximately 2 weeks ago the facility policy changed. RN #7 identified the licensed nurses will no longer be doing weekly body audits and will only chart by exception. c. A physician order dated 10/24/24 directed the use of a LAL mattress, check function and placement every shift and set to comfort for wound. The annual MDS dated [DATE] identified Resident #14 had severely impLALed cognition, was occasionally incontinent of bowel and frequently incontinent of bladder, required moderate assistance for rolling side to side or transfers and maximum assistance for sitting to lying position on side of bed. Further, Resident #14 was at risk for pressure ulcers and had one stage III pressure ulcer of the sacral region. Review of the Weight Record Summary dated 11/1/24 identified the resident weighed 162.0 lbs. Review of the Weight Record Summary dated 2/8/25 identified the resident weighed 164.2 lbs. Observation on 2/23/25 at 9:10 AM and 10:30 AM identified Resident #14 was lying in bed with LAL mattress set at 200 lbs., 35.8 lbs. more than the resident's weight. Observation on 2/24/25 at 7:32 AM identified Resident #14 was lying in bed with LAL mattress set at 200 lbs. , 35.8 lbs. more than the resident's weight. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 (Corporate [NAME] President Clinical Operations) on 2/24/25 at 9:30 AM indicated that the facility uses 2 primary LAL mattresses and based on manufacturer booklets the LAL mattresses were to be set to the resident's weight. RN #2 indicated that he would provide the manufacturer booklets. Interview with RN #7 on 2/24/25 at 10:15 AM indicated that RN #1, the Infection Preventionist, is responsible for tracking which residents have a LAL mattress, why they have the LAL mattress, and to ensure there is a physician order and a care plan for the LAL mattress. RN #7 indicated that all LAL mattresses are set to a resident's weight unless a resident is cognitively intact and requests the setting to be a little softer or firmer. RN #7 indicated that if the resident requested a different setting than the setting based on their weight, that setting would be added to the care plan and a physician's order would be obtained. RN #7 indicated that every shift the charge nurses are responsible to check that the placement, function and setting of the LAL mattress. Interview with RN #1 (Wound Nurse) with RN #9 (Vice President of Clinical Operations) on 2/24/25 at 10:44 AM identified RN #1 is responsible to maintain a list of LAL mattresses in use, however, RN #1 was unable to provide a list of residents on LAL mattresses currently while in his office. RN #1 indicated that all residents on an LAL mattress will have a physician's order stating they are on an LAL mattress, and it will be set to comfort, not weight. RN #1 indicated that for all the LAL mattresses, he ensures the physician's orders direct the mattresses are all set to comfort. RN #1 indicated that Resident #14 is on an LAL mattress because of a stage III pressure ulcer to the coccyx. RN #1 indicated that the LAL mattress was used to promote healing and prevent any new pressure ulcers. RN #1 indicated that he did not have the manufacturer books for the LAL mattresses that were in the facility, so was not aware if the manufacture recommendations say to set the LAL mattress to a resident's weight. Interview with RN #9 on 2/24/25 at 10:44 AM indicated that Resident #14's LAL mattress was set to comfort or weight and there is a physician order for the LAL mattresses. RN #9 indicated that Resident #14 weighs 165 lbs. and the dial would be set at that range, RN #9 indicated that if the dial was not set to weight and was set because Resident #14 had requested it for comfort to a harder or a softer setting it would be in the physician order and in the care plan. Interview with APRN #3 (Wound APRN) on 2/25/25 at 9:20 AM indicated that LAL mattresses are typically used for the treatment of an existing pressure ulcer, to help with off-loading and should be set to a resident's weight. Review of the Wound and Skin Care Protocols identified the purpose was to prevent pressure ulcer formation by identifying those residents who are at risk for pressure ulcers and to develop appropriate interventions. All residents will be assessed by the nurse for risk of skin breakdown, utilizing the Braden Scale upon admission, readmission and every week for the first 4 weeks. Weekly body audits will be completed on shower day by a licensed nurse and all skin areas will have weekly documentation until healed. Review of the Manufacturer Booklet for the LAL mattress on Resident #14's bed directed to obtain the resident's weight and set the control knob to that weight setting on the control unit. Although requested, a facility policy for LAL mattresses was not provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident, (Resident #34) reviewed for range of motion, the facility failed to ensure appropriate care and use of adaptive devices was provided in accordance with the plan of care and failed to ensure a physician's order was maintained that directed the use of an adaptive device for a resident with limited mobility. The findings include: Resident #4 had diagnoses that included hemiplegia/hemiparesis (weakness and paralysis) following a stroke affecting the right side and was receiving hospice services. The quarterly MDS dated [DATE] identified Resident #3 had severely impaired cognition, had mobility impairment to one side of the body and was dependent with dressing. The care plan dated 1/14/25 (original date 2/16/23) identified Resident #34 was at risk for contractures of the right hand related to right hemiparesis. Interventions included applying a resting hand splint after morning care, remove after evening care and use a rolled washcloth after the splint is removed. Physician's orders 2/1/25 (original order date 8/11/22) directed to apply a right resting hand splint during the 3:00 PM to 11:00 PM shift after evening care and remove after morning care with skin checks. (This is in conflict with the care plan initiated on 2/16/23 that indicates to apply the resting hand splint after morning care, remove after evening care and use a rolled washcloth after the splint is removed). A physician's order dated 2/18/25 directed to discontinue the right resting hand splint application during the 3:00 PM to 11:00 PM shift after evening care and remove after morning care with skin checks. Observation on 2/23/25 at 8:35 AM identified Resident #34 lying in bed, the right hand in a contracted position with no splint and no rolled washcloth applied. (Per the care plan, the resident should have a rolled washcloth after the splint is removed). A second observation on 2/23/25 at 10:12 AM identified Resident #34 was dressed in bed and the right hand was in a contracted position with no splint and no rolled washcloth applied. (Per the care plan, the resident should have the splint applied after morning care). Interview with NA #5 on 2/24/25 at 10:44 AM, Resident #34's nurse aide, identified she had provided and completed morning care for Resident #34. Interview with LPN #3 on 2/24/25 at 11:43 AM identified he was the assigned nurse for Resident #34 during the 7:00 AM to 3:00 PM shift. LPN #3 identified all required morning care had been completed for Resident #34. LPN #3 identified that Resident #34 had no refusals of care that morning and no significant history of refusal of care other than medications at times. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A third observation on 2/24/25 at 12:09 PM with LPN #4 identified Resident #34 was in bed with no splint or rolled washcloth applied to the right hand. Interview with LPN #4 on 2/24/25 at 12:09 PM identified Resident #34 was in bed with no splint or rolled washcloth applied to the right hand. LPN #4 identified the assigned nurse aide was responsible for applying the splint. Subsequent to surveyor inquiry, the splint was placed by LPN #4 without difficulty. A subsequent interview with NA #5 on 2/24/25 at 12:10 PM identified, other than meals, Resident #34 did not refuse any care this morning (2/24/25). NA #5 further identified she was not regularly assigned to Resident #34, was unaware the resident required the use of a splint after morning care and had not referred to the care card prior to providing care. NA #5 further identified the Director of Rehabilitation had assisted with morning care this morning and mentioned obtaining something for Resident #34's right hand. Interview and review of the clinical record with the Director of Rehabilitation on 2/24/25 at 1:25 PM identified Resident #34 required a splint due to a contracture of the right hand. The Director of Rehabilitation identified she did assist with care earlier that morning and had observed that Resident #34's right hand was not clean and was going to look into the matter. The Director of Rehabilitation identified that rehabilitation services were responsible for the assessment and recommendation of the right hand splint for Resident #34. The Director of Rehabilitation further identified that the physician order for the right hand splint had been discontinued on 2/18/25, specifically by her, but she was unable to explain why she discontinued the order as Resident #34 needed the splint due to a contracture of the right hand. Interview with APRN #1 on 2/24/25 at 1:27 PM identified the physician order for the right hand splint should not have been discontinued as Resident #34 needed the splint and not having the splint could place the resident at risk for skin integrity issues and further contracture. The physician's order was reinstated on 2/24/25 that directed the application of the resting hand splint to the residents right hand on during the 3:00 PM to 11:00 PM shift after evening care and off after morning care with skin checks. Interview with the DNS on 2/25/25 at 7:54 AM identified she would expect nurse aide staff to ensure the residents right hand would kept clean and dry, and the splint would be applied according to rehabilitation recommendations. Interview with NA #7 on 2/25/25 at 1:27 PM identified she frequently provides care to Resident #34 during the 7:00 AM to 3:00 PM shift and is aware the resident requires the application of a splint on the right hand after morning care. NA #7 further identified she has not previously observed Resident #34 refusing to wear the splint. Additionally, NA #7 indicated she had not previously observed that the splint or washcloth was already in place on the resident's right hand at the beginning of the 7:00 AM to 3:00 PM shift. Interview with APRN #1 on 2/25/25 at 1:38 PM identified she would expect to be notified and have a discussion before splint discontinued. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician/APRN progress notes and nurses notes dated 2/1/25 through 2/18/25 failed to reflect Resident #34 refused the application of the right hand splint. Review of the Splints and Orthotic Devices policy directed splints were provided to maintain range of motion, ensure proper joint alignment, promote skin integrity and prevent further contracture. Therapy and/or physician will issue the appropriate positioning splint determined by resident need. A physician's order will be obtained for the positioning device and include the wearing schedule. The skin will be observed before and after the removal of the splints and documented on the TAR. The resident care plan and care card will reflect the use of the splint.

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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 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** 37721 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents, (Resident #5) reviewed for nutrition, the facility failed to ensure weights were obtained according to policy. The findings include: Resident #5 had diagnoses that included history of a heart attack and recent influenza. The annual MDS dated [DATE] identified Resident #6 had moderately impaired cognition and was independent with eating. The care plan dated 10/16/24 identified Resident #16 had a potential for nutritional decline related to multiple medical problems. Interventions included to provide diet, supplements and weight as ordered. Physician's order dated 11/14/24 directed to obtain weekly weights. The weight log dated 11/27/24 identified Resident #5 weighed 121.2 lbs. A Nutritional assessment dated [DATE] identified Resident #5 experienced no significant weight change in the past one or six months, had mostly good intake with house supplements in place to help meet needs. A Nutritional progress note dated 12/20/25 identified the monthly weight was pending and that Resident #5 had a history of weight loss. A house supplement was added. A physician's order dated 1/10/25 directed to discontinue weekly weights. Review of the weight log failed to reflect a January 2025 weight had been obtained. The weight log dated 2/21/25 identified Resident #5 weighed 113.2 lbs., an 8lbs. weight loss or 6.60 %. Further review of the weight log identified that between 11/14/24 - 1/10/25, 3 of the 9 weekly weights were not obtained per the physician's order. Interview with the Dietitian on 2/24/25 at 11:34 AM and 2/25/25 at 7:15 AM identified any weight discrepancy greater than 5% requires a reweight, however, he was unable to specify a time frame for when this should occur. The Dietitian identified the aides were self-directed in obtaining a reweight but he would follow up if a reweight was not recorded. The Dietitian identified a monthly weight was not obtained for the month of January and should have been. The Dietitian further identified there were occasions where other resident's monthly weights were not documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 identified the nurse aide staff were responsible for obtaining resident weights and were self-directed in obtaining and documenting reweights for weight loss greater than 5%. However, she would request a reweight for weight changes of 2 - 3 lbs. Most reweights were obtained immediately, but no later than 24 hours. Once a weight change greater than 5% was confirmed, the dietitian and physician were to be notified. An interview with the DNS on 2/25/25 at 7:43 AM identified she would expect a documented reweight for any weight discrepancy greater than 5% and that weights should be obtained in accordance with policy. Review of the Weight Monitoring policy directed that weights were to be taken and recorded on a weight sheet or electronic medical record. A weight discrepancy (plus or minus) 5 lbs. requires a reweight. The charge nurse will review the weight and compare it to the previous weight to determine if there is a 5% change in 30 days or 10% in 180 days. Significant weight changes would be reported to the DNS, responsible party, dietitian and physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47457 Based on review of facility documentation, facility policies, and interviews, the facility failed to ensure food temperatures were routinely monitored prior to food service. The findings include: The facility's Cooked Foods Temperature Chart identified food temperatures must be documented when the food item completes the cooking process; supper food items included soup, meat, puree meat, ground meat, potato/starch, puree starch, vegetable, puree vegetable, and other. Review of the Cooked Foods Temperature Charts dated 12/17/24 through 1/4/25 and 1/12/25 through 2/22/25 failed to identify supper temperatures were documented on the following dates: 12/18/24 only soup and meat temperatures were documented, 12/25/24, 12/27/24, 12/30/24, 12/31/24 1/3/25, 1/4/25, 1/13/25, 1/14/25, 1/16/25, 1/18/25, 1/20/25, 1/24/25, and 1/30/25. The Cooked Foods Temperature Charts were not provided between 1/5/25 through 1/11/25. The facility's Meal Serving Temperature Chart identified serving temperatures must be taken no earlier than 10 minutes prior to meal service; supper food items included soup, meat, puree meat, ground meat, potato/starch, puree starch, vegetables, puree vegetable, salad, chilled dessert, milk, hot beverage and other. Review of the Meal Serving Temperature Charts dated 12/17/24 through 1/4/25 and 1/12/25 through 2/22/25 failed to identify supper temperatures were documented on the following dates: 12/16/24, 12/17/24, 12/18/24, 12/19/24, 12/20/24, 12/21/24, 12/22/24, 12/23/24, 12/25/24,12/26/24,12/27/24, 12/30/24, 12/31/24, 1/2/25, 1/3/25, 1/4/25, 1/13/25, 1/14/25, 1/16/25, 1/18/25, 1/20/25, 1/23/25, 1/24/25, 1/27/25, 1/28/25, 1/30/25, and 2/1/25. The Meal Serving Temperature Charts were not provided between 1/5/25 through 1/11/25. Interview with the Night [NAME] (Cook #1) on 2/24/25 at 1:20 PM identified that food temperatures should be documented before being served to ensure the temperatures are safe so no residents get sick and to ensure hot food temperatures are maintained and not served cold. [NAME] #1 indicated that he always obtains temperatures of all the food items prior to service, but he has forgotten to write them down in the chart, sometimes. Interview with the Director of Dietary on 2/24/25 at 1:39 AM identified that the facility has 5 cooks, four are Servsafe certified, including [NAME] #1, and one new cook is scheduled for Servsafe in March. The Director of Dietary indicated that the cook is responsible to obtain and document food temperatures before food service, and she was aware that there was missing temperature documentation for supper food items; she has been educating the night cooks on the importance of documenting the food temperatures and the documentation has gotten better but remains a work in progress. Inservice education dated 2/24/25 identified education was provided to [NAME] #1 on the topic of documenting cooking temperatures, the procedure for taking temperatures, and reviewing the importance of logging daily temperatures for food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Procedure for Taking Serving Temperatures policy directs the facility to establish the proper procedure for taking serving temperatures to assure all foods are served at the correct temperatures. The procedure includes measuring internal temperatures of food using a properly calibrated bimetal stem thermometer, recording the temperature on the Serving Food Temperature Chart if the temperature meets the guidelines in the second column, if the food does not meet the minimum/maximum temperature, continue the cooking or chilling process until the proper level is reached by rechecking the temperature periodically, serving temperatures should be taken when food is placed in steam table, no longer than 15 minutes before serving time. The Temperature Control During Food Preparation policy directs for the proper management of time and temperature during food preparation in order to minimize bacterial growth. Except during preparation, cooking, or cooling, food temperatures shall be maintained at 135 degrees Fahrenheit (F) or above or at 41degrees F or below.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 2 residents, (Resident #25 and 37) reviewed for infection control, the facility failed to develop and implement policies to ensure a resident with a history of colonized multidrug resistant organism (MDRO) and a surgical wound was provided care in accordance with infection control practices and failed to implement policies regarding the use of personal protective equipment (PPE) while providing direct care and for Resident #37 the facility failed to ensure enhanced barrier precautions (EBP) were initiated for a resident with an indwelling medical device. The findings include: 1. Resident #25 had diagnoses that included cutaneous abscess of the groin requiring aftercare following surgery. The care plan dated 1/21/25 identified Resident #25 had a surgical wound, and a history colonized Methicillin-resistant Staphylococcus aureus, MRSA (bacteria resistant to many antibiotics) requiring advanced barrier precautions. Interventions included to instruct visitors and caregivers to wear a disposable gown and gloves during physical contact with the resident and provide treatments as ordered. The quarterly MDS dated [DATE] identified Resident #25 was cognitively intact and required one person assist with bed mobility, two person assist with transfers and had a surgical wound requiring wound care. a. Observation on 2/23/25 at 9:38 AM identified Resident #34 was in a semi-private room with no signage or accessible PPE nearby and no other identifiable indicators on the door or name plate signifying the resident was on enhanced barrier precautions (EBP). An interview with RN #1 on 2/23/25 at 2:33 PM identified he was the Infection Preventionist (IP) for the facility. RN #1 identified only residents with specific novel/targeted MDRO's required enhanced barrier precautions. RN #1 further identified that while Resident #25 had a history of MRSA and an open surgical wound, he/she did not require any special precautions. If required, a resident would have signage, or an orange sticker placed on the name frame indicating the resident on EBP and PPE would be placed outside the room. An interview with the DNS on 2/23/25 at 2:45 PM identified it would be her expectation that a resident with a known history of any colonized MDRO and wound be placed on enhanced barrier precautions. Resident #25 was subsequently placed on EBP. A review of the facility policy for enhanced barrier precautions directed the facility to adhere to the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS) guidelines related to enhanced barrier precautions to prevent transmission of MDRO's. The facility will implement EBP when contact isolation does not apply for high contact resident care activities and will include unhealed surgical wounds regardless of MDRO colonization or infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075144	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Guilford	10 Boston Post Rd Guilford, CT 06437

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 1/29/25 identified Resident #37 received dialysis due to chronic kidney disease (CKD), 3 times per week, and was at risk for bleeding, infection, and septic shock. The care plan further identified Resident #37 had a right central line dual-lumen tunneled catheter (inserted on 10/24/24) through which he/she received dialysis treatments. Interventions included observing the right central venous catheter for any signs and symptoms of infection and notifying the physician immediately; interventions failed to include EBP (enhanced barrier precautions, a CDC recommendation to provide guidance for use of personal protective equipment in facilities to prevent the spread of MDRO's). The care plan identified Resident #37 required assistance with ADL's status post recent hospitalization for respiratory failure and end-stage renal disease (ESRD) now requiring dialysis. Interventions included incontinence care per facility policy and assisting with ADL's when needed. Observation and interview with LPN #2 on 2/23/25 at 10:38 AM failed to identify signage for EBP in an area that was visible and failed to have PPE readily accessible for use. LPN #2 identified that she was aware that Resident #37 required EBP because of his/her dialysis access and that she does wear PPE while providing care, but she [NAME] the PPE from another room down the hall. LPN #2 was not sure why there was no signage for EBP on Resident #37's door or why PPE was not readily available, but she would place appropriate EBP signage and put a PPE bin outside his/her room. Interview with NA #1 on 2/23/25 at 10:45 AM identified that she was not told that Resident #37 was on enhanced barrier precautions, and as a result she has not worn PPE while providing him/her with care. NA #1 indicated that she did not know why Resident #37 would require enhanced barrier precautions, and there was no sign directing staff to wear PPE while providing care or a bin outside his/her room with PPE. Interview with the Infection Control Nurse (RN #1) on 2/23/25 at 2:33 PM identified that residents with indwelling devices, wounds, and history of MDRO's should be on enhanced barrier precautions. RN #1 indicated that the nursing staff was educated on EBP in April of 2024, and staff would be able to identify residents on EBP by signage on the door and an orange sticker near their name on the wall plate. RN #1 indicated that Resident #37 should be on EBP, due to his/her permacath for dialysis. RN #1 was unsure why Resident #37 had not been on EBP, but he would put him/her on EBP. Observation of Resident #37's name plate on 2/23/25 at 2:49 PM failed to identify an orange sticker identifying the need for EBP. Subsequent to surveyor inquiry, a physician's order dated 2/24/25 directed for enhanced barrier precautions due to indwelling medical device, every shift. Interview with the DNS on 02/25/25 at 8:42 AM identified that she would expect Resident #37 to have been placed on enhanced barrier precautions, due to his/her dialysis permacath. The DNS indicated that upon admission the RN supervisor should have placed Resident #37 on EBP, but it would also be up to the Infection Control Nurse to ensure a resident on dialysis with a permacath was identified and placed on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Enhance Barrier Precautions policy directs the facility to implement enhanced barrier precautions during high-contact resident care activities, for those residents per the current CDC Novel Targeted MDRO list and with indwelling medical devices. Examples of high-contact resident care activities include dressing, bathing/showering/providing hygiene, transferring, changing linens, changing briefs or assisting with toileting. The facility will implement enhanced barrier precautions to include any resident with an indwelling medical device or chronic wounds regardless of MDRO colonization or infection status. Enhanced barrier precautions will remain in effect for the duration of the resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at a higher risk. The policy further directs that appropriate signage for EBP will be visible and appropriate PPE and hand sanitizer will be readily accessible for use. Staff will perform hand hygiene and don PPE before providing high-contact care to the resident and doff PPE and perform hand hygiene after providing high-contact care to the resident. 47457