STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075181	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Watertown	35 Bunker Hill Rd Watertown, CT 06795

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policies review, and interviews for one of three residents (Resident #1) reviewed for a change in condition, the facility failed to ensure an RN assessment was completed timely after staff identified a change in condition that resulted in a transfer to the hospital, and failed to ensure an RN assessment was completed timely after a return to the facility from the hospital. The findings include: Resident #1 was admitted to the facility with diagnoses that included stroke, thyroid disorder, and hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, moderate cognitive impairment, had no behaviors, required assistance with ADLs and transfers, and received no antianxiety or antidepressant medication. A Resident Care Plan (RCP) dated 9/12/2024 identified Resident #1 had cardiovascular disease due to bradycardia and hyponatremia. Interventions directed to obtain vital signs and provide medications as ordered. A nursing change in condition note (Situation, Background, Assessment, Recommendation - SBAR) written by LPN #1 dated 12/30/2024 at 8:38 PM identified Resident #1 had become combative, and no intervention was improving the behavior, and identified the behavior was worsening noting Resident #1 was now a danger to self. A one-time antianxiety medication was obtained and administered, although Resident #1 spit it out. A nursing note dated 12/30/2024 at 11:59 PM written by LPN #1 identified the day shift nurse, LPN #2, reported Resident #1 was very agitated and became more agitated as the afternoon proceeded and found Resident #1 standing and wanting to climb out of the window to see a man and a baby. Upon redirection, Resident #1 began to hit, scratch and yell at staff. The APRN was notified and when Resident #1 spit out the ordered antianxiety medication, the APRN ordered Resident #1 to be transferred to the hospital for evaluation. Person #1 (Resident #1's responsible party) was notified and refused the transfer until Person #1 was able to see Resident #1. Resident #1 became more agitated with Person #1 in attendance, verbally threatening to hit Person #1 and Resident #1 was transferred to hospital for evaluation. Record review failed to identify an RN assessment was completed when staff identified a change in condition on 12/30/2024. B. Review of EMS (Emergency Medical Services) run sheet dated 12/30/2024 identified EMS was called at 9:36 PM and left the facility for the transport to the hospital with Resident #1 at 10:03 PM. A hospital Discharge summary dated [DATE] at 12:51 PM identified Resident #1 was evaluated by psychiatric services initially on 12/30/2024, was determined to be a danger to self and was to be held for a psychiatric admission. Psychiatric services changed with recommendations to decrease Buspar to 5 mg daily for five (5) days and then to discontinue the Buspar, recommended to add Risperidone 0.25 mg (antipsychotic medication) as needed for agitation, and to be followed up by geriatric psychiatric services. A nursing note written by LPN #3, dated 1/1/2025 at 7:49 PM (1 day, 21 hours and 46 minutes after transfer to the hospital) identified Resident #1 returned to the facility from the hospital. Review of the facility twenty-four hour report sheets dated from 12/30/2024 to 1/2/2025 (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	failed to identify any documentation for Resident #1, other than documentation of his/her return to the facility from the hospital on 1/1/2025. Review of Resident #1's medical record failed to identify an RN assessment was completed after Resident #1's return to the facility on 1/1/2025. Interview and record review with RN #3 on 1/8/2026 at 1:47 PM identified she was the RN supervisor working on 12/30/2024 when Resident #1 was transferred to the hospital and she stated she could not recall assessing Resident #1 on 12/30/2024. RN #3 stated if she had assessed Resident #1, she would have documented the assessment. RN #3 stated an RN assessment should be completed for a change in a resident's condition and upon admission/readmission. RN #3 stated assessments should have been completed on 12/30/2024 when the change was identified and on 1/1/2025 when Resident #1 returned from a hospital, and it should be documented in the medical record. RN #3 stated if it was not documented, it would not be considered done. Interview failed to identify why RN assessments were not completed. Interview with the DON on 1/12/2026 at 9:28 AM identified that she would expect an RN to complete as assessment if a resident experienced a significant change in condition that resulted in a transfer to the hospital for evaluation. She did not know why RN #3 did not complete an assessment on 12/30/2024 or why the RN supervisor, RN #2, did not complete an assessment on 1/1/2025. RN #2 (supervisor on 1/1/2025) was unavailable for interview during the survey. The facility Change in Resident Condition Policy dated July 2018, directed in part, when there is a significant change in condition or a resident's physical, mental or emotional status, an RN assessment will be conducted. The facility policy Nursing Documentation directed in part, that documentation should occur as soon as possible after the assessment was completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policies review, and interviews for one of three residents (Resident #1) reviewed for a change in condition, the facility failed to ensure the clinical record was complete and accurate to include vital signs were recorded timely after a change in condition was identified. The findings include: Resident #1 was admitted to the facility with diagnoses that included a history of stroke, convulsions, thyroid disorder, and hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, moderate cognitive impairment, had no behaviors, required assistance with ADLs and transfers, and received no antianxiety or antidepressant medication. A Resident Care Plan (RCP) dated 9/12/2024 identified Resident #1 had cardiovascular disease due to bradycardia and hyponatremia, and had accusatory behaviors at times. Interventions directed to obtain vital signs and provide medications as ordered. A nursing note dated 12/7/2024 identified RN #3 was called to assess Resident #1 who became unresponsive during morning care while moving his/her bowels. Resident #1 was unresponsive to tactile and verbal stimuli with a carotid (neck) pulse of 30 beats per minute. Resident #1 became responsive after a few minutes with vital signs: blood pressure 90/60 (baseline 122 to 132/68 to 74), pulse 50 (baseline 55 to 72), and respiratory rate 14. The APRN was updated. A physician order dated 12/7/2024 directed to obtain vital signs every shift for three (3) days. Record review identified although vital sign monitoring was initiated as ordered on 12/7/2024 at 3 PM, vital signs were not recorded every shift for three (3) days. Review of the Medication Administration Record (MAR) for December 2024, identified all the shifts for the three (3) days (12/7, 12/8, 12/9 and 12/10/2024) were initiated to indicate the vitals signs were obtained. Additional review identified the MAR did not record what the vital signs were. Review of the nursing notes and vital sign records in the clinical record failed to identify the vital signs obtained were recorded. The following shifts had initials signed on the MAR to indicate the vital signs were obtained, but no vital signs obtained were documented in the record:12/7/2024 night shift12/8/2024 day, evening, and night shifts12/9/2024 day, evening, and night shifts12/10/2024 day shift Interview with the DON on 1/12/2026 at 9:28 AM identified she expected the nursing staff to follow a physician's order. The physician order was for vital signs every shift for three (3) days and the staff should have obtained and documented the vital signs (temperature, blood pressure, pulse and respirations) in the medical record. The DON stated she did not know why the nursing staff did not document the vital signs as ordered. The facility Nursing Documentation Policy directed in part, that documentation should occur as soon as possible after care was completed.