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	03/27/2026

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

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews for 1 of 2 residents (Resident # 10) reviewed for Pressure Ulcers, the facility failed to ensure staff accurately review the clinical record and code the pressure ulcer stages on the Minimum Data set assessment to reflect the resident's condition. The findings include: Resident # 10's diagnosis includes dementia. The wound care physician progress notes dated 3/3/20206 and 3/10/2026 indicated Resident #10 had a stage 3 pressure ulcer on the coccyx (center of lower back) and a stage 3 pressure ulcer of the thoracic spine which had reopened and indicated the wound was previously a stage 3 wound). The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was at risk of pressure ulcer, had unhealed pressure ulcers, 1 stage 2 pressure ulcer, 1 stage 3 pressure ulcer and 1 stage 4 pressure ulcer all of which was not present on admission. Resident #10's care plan dated 3/16/2026 indicated Resident #10 had a potential for skin breakdown related to limited mobility and incontinence. Interventions included providing a low air loss mattress (to reduce pressure), to encourage repositioning side to side when in bed, incontinent care after each episode of incontinence. An interview and clinical record review on 3/25/2026 at 2:25 PM with Registered Nurse(RN #2) and Licensed Practical Nurse(LPN #12) indicated even though RN #2 viewed the wound with the nurse caring for the resident both had concluded it was a stage 2 pressure ulcer; the wound physicians progress notes should have been looked at as well to make the determination as how to code the MDS. LPN #12 indicated the MDS would be modified to reflect the correct pressure ulcer status for the resident at that time.

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	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations of medication administration, review of policy and staff interviews for 3 of 11 residents (Residents #37, #47, and #48) reviewed for medication administration, the facility failed to identify residents prior to administering their medications in accordance with facility policy. The findings included: 1.Resident # 37's diagnoses included Transient Ischemic Attack (TIA), depression, cerebrovascular disease, hyperlipidemia and hypertension.The physician's orders and Medication Administration Record (MAR) for February 2026 and March 2026 directed licensed staff to administer the following: acidophilus probiotic, 1 billion IU's, daily for supplementationEliquis 5.0 Milligrams (MG) by mouth twice a day Folic Acid 1.0 MG by mouth daily Levetiracetam 500 MG by mouth twice a day antiseizure medicationSenna Plus 8,6-50 mg one tablet by mouth twice a day for constipationVitamin B-1, 100 milligrams, daily for supplementationObservations made during medication administration identified the following:On 3/23/26 at 10:28 AM, Resident #37 was administered the following medications:-One tablet of acidophilus probiotic, 1 billion IU's, daily for supplementation-One tablet of Eliquis, 5 milligrams, twice daily for atrial fibrillation-One (1) tablet folic acid, 1 milligram, daily for supplementation-One (1) tablet Levetiracetam, 500 milligrams, twice daily for seizures-Two (2) tablets Senna Plus, 8.6-50 milligrams, twice daily for constipation-One (1) tablet Vitamin B-1, 100 milligrams, daily for supplementationHowever, upon administering the medications to Resident #37, LPN #6 identified him/her by name only. Interview with LPN #6 on 3/23/26 at 10:32 AM identified the facility's standard of practice was to identify the resident prior to administering their medication(s) by either verifying their name on their identification bracelet, asking their name, and/or verifying their date of birth . LPN #6 further indicated he/she did not identify Resident #37 prior to administering his/her medications because he/she already knew him/her.2. Resident # 48's diagnoses included depression, Transient Ischemic Attack (TIA), cardiac pacemaker, hypertension and atrial fibrillation.The physician's orders dated February 2026 through March 2026 directed the licensed staff to administer the following:Eliquis 2.5 mg by mouth twice a day for atrial fibrillationMetoprolol 100 mg by mouth twice a day for high blood pressureOn 3/24/26 at 10:21 AM, Resident #48 was administered the following medications:-One tablet of Eliquis, 2.5 milligrams-One tablet of metoprolol, 100 milligramsHowever, upon administering the medications to Resident #48, LPN #7 identified him/her by name only.Interview with LPN #7 on 3/25/26 at 4:00 PM identified the facility's standard of practice was to identify the resident by their name band prior to administering their medication(s) and if the resident did not have a bracelet on, to ask their name and verify their date of birth . LPN #7 further indicated he/she had only asked Resident #48's name prior to administering his/her medication(s) as she was nervous.3.Resident # 47's diagnoses included vascular dementia with behavior disturbances , anxiety, adjustment disorder, depression and bilateral knee pain.The physician's orders dated February 2026 directed the licensed staff to administer the following medication quetiapine 25 mg by mouth three times a day for dementia with behavioral disturbanceOn 3/25/26 at 11:38 AM, Resident #47 was administered the following medication:-One tablet quetiapine, 25 milligrams, three times daily However, upon administering the medication to Resident #47, LPN #8 identified him/her by name band only.Interview with LPN #8 on 3/25/26 at 11:40 AM identified the facility's standard of practice directed to identify the resident by their name band and date of birth but only verified his/her name on Resident #47's name badge as he/she did not have a computer close by to verify the resident's date of birth had he/she asked. Interview with the Regional Clinical Director on 3/26/26 at 3:22 PM identified the facility's standard of practice directed to identify the resident using two (2) identifiers (name bracelet, picture on electronic medical record, resident to self-identification if able, or two (2) staff that could confirm the resident's identity) prior to administering the resident's medication.The Medication Administration policy directed to confirm the resident's identity by using at least two (2) identifiers (e.g.name and date of birth) before administering the medication and to ensure the right resident, right medication, right dose, right route and right time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy and staff interviews for 1 of 2 residents (Resident # 91) reviewed for nutrition, the facility failed to reweigh a resident with a significant weight discrepancy in a timely manner and failed to implement interventions in a timely manner after a confirmed weight loss. The findings include: Resident #91's diagnoses included arthritis of the knee, anxiety, and depression.A physician's order dated 10/1/2024 directed the resident be weighed monthly on the 1st of the month.A quarterly MDS assessment dated [DATE] identified Resident #91was moderately cognitively impairment and was dependent for eating and oral hygiene. The MDS assessment further identified Resident #91 had not experienced significant weight loss.A care plan dated 11/24/2025 identified Resident #91 had potential for nutritional decline. Interventions included providing fortified foods and supplements as ordered and weighing the resident as ordered.A review of documented weights for Resident # 91 identified the following: On 1/1/2026, Resident #91 weighed 160 pounds (lb.) and had been weighed by wheelchair. On 2/1/2026, Resident #91 weighed 151.6 lb. by wheelchair, which was an 8.4 lb. weight loss, or 5.2% loss in one month.A review of nursing progress notes failed to identify documentation of any resident refusals of weights and failed to identify interventions for the potential weight loss of 5.2% on 2/1/2026.A review of provider orders identified a physician's order for an immediate (STAT) reweight dated 2/12/2026 at 1:16 PM.On 2/12/2026, Resident #91 weighed 149.9 lb. by wheelchair, which was a 10.1 lb. weight loss or 6.3% loss from the initial 1/1/2026 weight.A dietician's note dated 2/19/2026 (identified that Resident #91 had a significant weight loss of 6.3% over one month) based on the 2/12/2026 weight of 149.9 Lb. The note further identified a house supplement twice daily was recommended, as well as to monitor intake and weight.On 3/24/2026 at 12:52 PM, an interview with Licensed Practical Nurse (LPN#11) indicated when a resident had a 5 lb. weight loss, then the nurse should tell the provider, dietician, or supervisor. LPN #11 indicated he did not remember who he had notified regarding the suspected weight loss on 2/1/2026. LPN #11 further indicated on 2/12/2026, he was requested to reweigh Resident #91.On 3/25/2026 at 1:09 PM, an interview with the Dietician identified she did not recall being notified of a weight discrepancy on 2/1/2026 or of a confirmed weight loss on 2/12/2026. The Dietitian indicated that she found out about the weight loss when she reviewed the resident weights weekly and then addressed the weight loss during the facility's weekly at-risk meetings. The Dietician indicated on 2/5/2026, she reviewed Resident # 91's 2/1/2026 weight discrepancy and indicated during the at-risk meeting Resident #91 needed to be reweighed. The Dietician further indicated on 2/12/2026, she identified Resident #91 needed a reweight to confirm weight loss. The Dietitian indicated she reviewed the 2/12/2026 reweight on 2/19/2026 and ordered a house supplement at that time. The Dietician was unable to identify a rationale for starting interventions on 2/19/2026, which was 7 days after a weight loss was confirmed and 18 days after an initial weight discrepancy was identified.On 3/25/2026 at 1:45 PM, an interview with the Director of Nursing (DNS), the Assistant Director of Nursing (ADNS), and the Administrator were conducted. The administrator identified the facility policy did not specify how soon a reweight should be performed and that it depended on the significance of the weight loss. The Director of Nursing Services indicated a 5% weight loss in one month would be considered significant. The administrator further identified Resident # 91's 2/1/2026 weight discrepancy was discussed during the facility's at-risk meetings on 2/5/2026 and then again on 2/12/2026.A review of the facilities minutes for the Weekly At-Risk Meeting dated 2/5/2026 on 3/24/26 identified Resident #91 needed a reweight related to weight loss. A review of the facility's minutes for the Weekly At-Risk Meeting dated 2/12/2026 identified Resident #91needed a reweight related to weight loss.A review of the facility policy for Weight Monitoring identified that residents will be weighed monthly unless otherwise indicated by a Medical Doctor (MD) order and/or recommended by the registered dietician. Additionally, the policy indicated that if there (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a 5 lb. discrepancy, a reweight should be obtained and the charge nurse should review the weight and compare it to the previous weights to determine a significant weight change. A significant weight change would then be reported to a provider, responsible party, dietician, Director of Nursing Services, and care plan coordinator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and staff interview for 1 of 2 residents for (Resident #52) reviewed for Respiratory Care, the facility failed to ensure the individualized settings needed for the resident's Continuous Positive Airway Pressure (CPAP) machine were reflected in the physician's orders. The findings include: Resident #52's diagnosis includes obstructive sleep apnea. The physician's orders dated 2/14/2026 directed to provide a Continuous Positive Airway Pressure (CPAP) machine already programmed with settings to use every night, to apply the CPAP at bedtime after filling the water chamber with sterile or distilled water and to remove the CPAP in the AM upon waking, and to clean the facemask used with the CPAP machine with soap and water daily then place to air dry on clean surface, once dry place in the provide oxygen treatment bag. The admission Minimum Data Set assessment dated [DATE] indicated Resident #52 used a CPAP machine. The care plan dated 3/02/2026 indicated Resident #52 had sleep apnea. Intervention directed to apply and remove the CPAP as ordered. A discharge summary from the hospital dated 3/13/2026 at 3:00 PM indicated Resident #52 should continue CPAP every evening set at Positive End- Expiratory Pressure(PEEP) 9. An interview, clinical record review and facility policy review with the Director of Nursing Services (DNS) on 3/26/2026 at 2:30 PM identified the lack of individualized settings for the CPAP machine within the physician orders. The DNS indicated the settings were put in by Respiratory Therapy (RT), the nurse's do not change them as they are set on the inside. The DNS also indicated she/he did not have the settings, and the respiratory physician would have the required settings. Resident #52's CPAP settings were identified within the hospital Discharge summary dated [DATE]. The DNS indicated staff need to obtain a physician's order for the required settings as the resident could be transferred to another medical facility. The facility policy and procedure labeled CPAP/ Bilevel Positive Airway Pressure (BIPAP) indicated a CPAP/BiPAP order must be initiated upon receipt of a written order from the resident's physician and need to include the settings(pressure levels, mode of therapy) and any specific instructions for use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of policy and staff interviews for 1 of 2 residents (Resident #3) reviewed for dialysis, the facility failed to ensure consistent communications between the facility and dialysis clinic were maintained regarding the resident's dialysis treatments, pre and post treatment weights, vitals, medications administered and/or any concerns. The findings included: Resident #3 was admitted to the facility in October 2025. The residents' diagnoses included end stage renal disease, dependence on renal dialysis, and Type 2 diabetes mellitus.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 as cognitively intact (Brief Mental Interview for Mental Status (BIMS) of 15) and dependent with toileting, lower body dressing and noted the utilization of a wheelchair for transport.The Resident Care Plan (RCP) dated 1/29/26 identified Resident #3 received dialysis three times weekly due to chronic renal disease. Interventions directed to contact the dialysis center with questions regarding care.Review of the Dialysis Communication Book (a notebook used for communications between the dialysis facility and long-term care facility regarding Resident #3's treatments, pre and post treatment weights, vitals, and medications administered) failed to identify entries for treatments administered in February 2026 and March 2026.Although requested, the facility did not have additional notes/communications with the dialysis facility for February 2026 and March 2026 treatments to provide.Interview with LPN #2 on 3/26/26 at 11:02 AM (who was assigned to Resident #3 on dialysis days dated 2/2/26, 2/13/26, 2/16/26, 2/27/26, 3/9/26, 3/11/26, and 3/16/26) identified Resident #3 received dialysis treatments on Mondays, Wednesdays, and Fridays at the dialysis facility and would return to the facility during first shift (7:00 AM to 3:00 PM) following treatment. LPN #2 identified she/he would check the dialysis communication book following Resident #3's treatments and if nothing was logged, she/he would follow-up with a phone call to the facility, document the call, and inform the provider of any issues of concern. However, review of the Dialysis Communication Book failed to identify entries for any dialysis treatments administered in February 2026 and March 2026, and review of nursing notes failed to indicate calls were made to the dialysis facility regarding the resident's treatments.Interview with the Director of Nursing Services (DNS) on 3/26/26 at 12:52 PM identified the dialysis clinic had the responsibility of communicating any information regarding Resident #3's treatment, vitals, weight, medications or concerns with the facility following her/his treatment. However, the DNS did indicate if the treatment was not logged into the Dialysis Communication Book, he/she did expect staff to call the dialysis facility to request Resident #3's vitals, weight, medications, and/or any changes that may have occurred during Resident #3's dialysis treatment that day. Interview with LPN #11 (who was assigned to Resident #3's care on 2/4/26, 2/6/26, 2/9/26, 2/11/26, 2/18/26, 2/20/26, 3/4/26, 3/6/26, 3/13/26, 3/18/26, 3/20/26, and 3/23/26) on 3/26/26 at 3:40 PM identified she/he was not aware of a Dialysis Communication Book and did not recall being told to check it following Resident #3's dialysis treatments.The Hemodialysis policy directed a completed Intra- Agency Report (W-10) and/or communication sheet, current medication list, and any other pertinent information such as concerns, laboratory, diet, weight, vital signs, etc. were sent with the patient/resident for each dialysis treatment and the dialysis center would communicate with the facility using the communication tools listed above or the center's post dialysis form to communicate information with the facility post dialysis treatment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of the facility medication carts and storage rooms, review of facility policies and staff interviews, the facility failed to dispose of expired medications in 1 of 3 medication carts and1 of 2 medication storage rooms. The findings included: 1.Observation of the medication cart on Crestbrook on 3/24/26 at 10:27 AM identified the following:Narcan (used to reverse the effects of a life-threatening opioid emergency) two (2) single dose nasal spray devices, 0.003 fluid ounces (0.1 milliliters each) with an expiration date of 3/2026.An opened bottle of Gericare Milk of Magnesia (laxative), 16 fluid ounces, with an expiration date of 10/2025Interview with LPN #7 on 3/24/26 at 10:30 AM identified medications that are dated with month and year only expired as of the first of the month listed on the box/container therefore the medications should have been removed from the medication cart prior to their expiration. 2. Observation of the medication room located central to the [NAME] and Crestbrook wings on 3/24/26 at 10:50 AM identified the following:A container of Bisacodyl (laxative), 5 milligrams, 100 tablets with an expiration date of 9/2024A container of geri-dryl, (antihistamine) 25 milligrams, 100 tablets with an expiration date of 10/2025A container of stool softener, 100 milligrams, 200 tablets with an expiration date of 8/2025Interview with RN #4 on 3/24/26 10:57 AM identified expired medications should be disposed of prior to their date of expiration. She/he further indicated it was the responsibility of the Director of Nursing Services or Assistant Director of Nursing Services to evaluate the medication storage rooms and dispose of the expired medications.Interview with the Regional Clinical Director on 3/26/26 at 3:25 PM identified expired medications should be removed from circulation and discarded by the expiration date, and if the expiration date listed only the month and year of expiration, the facility staff was directed to dispose of the expired medication the first day of the month listed on the medication package. The Expired Medications and Medications with Shortened Expiration Dates identified the Director of Nursing Services or other authorized personnel would delegate to appropriate personnel the task of ensuring that all outdated or expired medications (with the exception of controlled substances, refer to controlled substances policy) were removed from the medication cart or other area where medication may be stored.