STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on clinical record reviews, review of facility documentation, and interviews for one of three sampled residents (Resident #1) reviewed for admission to the facility, the facility failed to notify the Medical Director when a resident, that had been accepted to be admitted to the facility, was denied admission after he/she arrived at the facility; and for one (1) of three (3) residents (Resident #11) reviewed for medication administration, the facility failed to ensure a provider was notified when a medication was omitted on twenty-four different occasions. The findings include: 1. Resident #1's diagnoses included acute respiratory failure, acute decompensated heart failure, and moderate malnutrition. The Inter-Agency Patient Referral Report (W-10) dated 3/1/25 at 5:24 PM identified Resident #1 was alert and oriented, required assistance with most Daily Living Activities (ADLs), was identified as a high fall risk, and had a physician order that directed Resident #1 to be transferred to a long-term care (LTC) facility on 3/1/24 for skilled nursing services following hospitalization. The Emergency Medical Services (EMS) report dated 3/1/25 identified Resident #1 was transferred to the facility from an acute care hospital, transferred from the stretcher into a bed, a Registered Nurse was notified, and care was transferred to the LTC facility staff on 3/1/25 at 8:43 PM. The Prehospital Care Report dated 3/2/25 identified EMS was dispatched at 9:17 AM to a private residence for complaints of an individual having difficulty breathing. The report identified Resident #1 explained he/she had been admitted to the hospital a few days ago for pneumonia and congestive heart failure and then was discharged for rehabilitation to a LTC facility. The report indicated Resident #1 explained he/she could not be accepted by the facility due to not having paperwork from the hospital, and Resident #1 had to go to his/her residence. The report identified Resident #1 was not in respiratory distress. Hospital documentation dated 3/2/25 identified the case manager left a message at the LTC at 8:10 AM with a return call from the LTC facility at 8:18 AM. The case manager's note indicated when inquired as to what happened with Resident #1 being admitted to their facility last night, 3/1/25, the facility staff member state My bad on this one, you know it was after 4:00 PM. The note identified Resident #1 explained he/she was escorted out of the LTC facility, it was ten (10) degrees. The note identified Resident #1 would be transferred to another LTC facility. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 3/17/25 at 10:41 AM identified Resident #1 arrived to the facility on 3/1/24 during the 3PM-11PM shift by ambulance from an acute care hospital for admission to the facility, was not able to be admitted because documentation for Resident #1 was not received, and Resident #1 left the facility around 12:00 AM on 3/2/25 to his/her residence. The Administrator indicated the facility was not aware Resident #1 was going to be admitted on [DATE], however the facility found out the following day on 3/2/25 from Admissions that Resident #1 was supposed to be admitted to the facility on [DATE]. The Administrator identified the facility had a centralized admissions process and the policy was for the facility to receive an update from admissions regarding pending admissions to the facility through a dashboard in the electronic medical record system, receive an admission notice through email, and receive a copy of the Inter-Agency Patient Referral Report (W-10) and hospital discharge summary for admission. In an interview with the 3PM-11 PM Nursing Supervisor, Registered Nurse (RN) 1, on 3/17/25 at 11:20 PM identified he was the nursing supervisor on 3/1/25 and the person responsible for completing new admissions. RN #1 indicated he was not notified prior to Resident #1's arrival to the facility that Resident #1 was to be admitted to the facility on [DATE] and facility policy was for staff to be notified of a pending admission prior to arrival. RN #1 identified upon Resident #1's arrival to the facility, the Inter-Agency Patient Referral Report (W-10) and hospital discharge summary was received from the ambulance personnel, and Resident #1 was placed in an available room. RN #1 identified since Resident #1 did not show up in the facility's electronic medical record system, he was unable to document the admission and informed the Director of Nursing (DON) and Administrator of the situation. RN #1 identified Resident #1 was not admitted to the facility on [DATE] because there was no paperwork on Resident #1 and he thought the reason for this was because Resident #1 was transported to the wrong facility. RN #1 indicated he called the ambulance to transfer Resident #1 back to the hospital, Resident #1 refused to go back to the hospital, and he was instructed by the DON to call the police when Resident #1 refused to leave the facility. RN #1 identified Resident #1, who was alert and oriented, left the facility to return home since Resident #1 was not able to be admitted to the facility. RN #1 indicated he did not obtain report from the hospital prior to Resident #1's arrival, did not contact the hospital after Resident #1 arrived, and indicated the DON was the person responsible for communication with the hospital on 3/1/25 following Resident #1's arrival at the facility. In an interview with the Regional Director of Nursing (DON) on 3/17/25 at 12:11 PM she identified she was the interim DON during the time of the incident. The Regional DON identified she was contacted on 3/1/25 at 10:30 PM, informed Resident #1 had arrived at the facility via ambulance for admission, and thought Resident #1 was at the wrong facility since Resident #1 was not in the facility's system, no admission notice was received, and the hospital did not call to give report prior to Resident #1's arrival. The Regional DON indicated she contacted facility admissions and spoke with the hospital to find out more information following Resident #1's arrival and was informed at 12:00 AM on 3/2/25 that there was a misunderstanding and Resident #1 was supposed to be admitted to the facility on [DATE]. The Regional DON identified she was informed Resident #1 had already left the facility because Resident #1 wanted to go home, and she then called Resident #1 and asked Resident #1 to return to the facility. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Medical Director on 3/27/25 at 9:35 AM identified he expected to be notified by a phone call or text message of an admission to the facility, at any hour during the day or night. The Medical Director indicated he should be notified if a resident was not able to be admitted for any reason. The Medical Director identified although he was not working the weekend of 3/1/25, the expectation was for him or the on-call provider to be notified prior to Resident #1 leaving the facility on 3/1/25. The Medical Director indicated no communication was received by the facility to inform him of the issue with Resident #1's admission until after Resident #1 left the facility. A follow-up interview with the Regional DON on 3/27/25 at 10:25 AM indicated she did not contact the Medical Director or the on-call provider prior to Resident #1 leaving the facility and was not aware Resident #1 arrived to the facility with a W-10 and hospital discharge summary. Interview with the Admissions Coordinator on 3/27/25 at 11:08 AM identified facility policy was for the Admissions Department to notify a facility of all pending admissions by sending an email directly to the center (facility) and by posting a notification to the center's (facility's) dashboard in the electronic system. The Admissions Coordinator identified information for pending admissions was put into the electronic system, which was called a lead, for anyone expected to be admitted and then had to be what was termed waitlisted in the system, in order for the facility to see the pending admission on the system dashboard. The Admissions Coordinator identified the lead for Resident #1 was created in the system on 3/1/25 and Resident #1 was expected to be admitted to the facility on [DATE]. The Admissions Coordinator indicated the reason for this was because of employee error. The Admissions Coordinator indicated admission Staff #1 was responsible for sending the notification to the facility on 3/1/25 and was unsure why it was not done. The Admissions Coordinator indicated she was the identified contact for any admission-related issues outside of business hours on 3/1/25, between 4PM-8AM, and expected to receive a call or text from the facility with any issues related to a pending admission during that timeframe. The Admissions Coordinator identified she received an email from the facility Administrator, which was sent on 3/1/25 at 9:00 PM, however she did not read the email until after midnight on 3/2/25. The Admissions Coordinator identified had she got a call or a text, she would have gotten the notification sooner and addressed the issues, and identified there was no facility process in place prior to the incident on the method to contact the identified on-call admissions contact after business hours. 2. Resident #11 had diagnoses that included chronic pain, low back pain, pain in the right knee, and neuropathic pain. A provider's order dated 2/1/2025 directed to administer pregabalin (a medication used to treat nerve pain) oral capsule 200 milligram (mg) three times a day at 9:00 A.M., 1:00 P.M., and 5:00 P.M. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, was continent of bowel and bladder, independent with ADLs, transfers, and ambulation. The MDS further identified Resident #11 had frequent pain and received scheduled and as needed pain medication. Review of Resident #11's Medication Administration Record (MAR) identified on February 12, 2025, at 9:00 A.M. the dose of pregabalin 200 mg was not administered. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurse's notes dated 2/12/2025 identified there was no documentation to reflect a provider was notified that Resident #11's pregabalin was not administered. Review of Resident #11's MAR from 2/24/2025 to 2/25/2025 identified that on February 24, 2025, at 9:00 A.M. the dose of pregabalin 200 mg was not administered, and that on February 25, 2025, at 9:00 A.M. the dose of pregabalin 200 mg was not administered. Review of the nurse's notes dated 2/24/2025 to 2/25/2025 identified there was no documentation to reflect a provider was notified that Resident #11's pregabalin was not administered. The Resident Care Plan dated 3/3/2025 identified that Resident #11 is at risk for pain or discomfort with interventions that directed medications as ordered, report unrelieved pain or increased pain to the APRN/MD, and observe for signs and symptoms associated with pain. Review of Resident #11's MAR for March 2025 identified that on 3/8/2025, at 9:00 A.M. the dose of pregabalin 200 mg was not administered, on 3/9/2025, at 9:00 A.M. and 1:00 P.M. the doses of pregabalin 200 mg were not administered, on 3/10/2025 at 9:00 A.M., 1:00 P.M., and 5:00 P.M. the doses of pregabalin 200 mg were not administered, on 3/11/2025, at 9:00 A.M. and 1:00 P.M. the doses of pregabalin 200 mg were not administered, on 3/18/2025, at 1:00 P.M. the dose of pregabalin 200 mg was not administered, on 3/20/2025, at 1:00 P.M. the dose of pregabalin 200 mg was not administered, on 3/21/2025, at 9:00 A.M. and 1:00 P.M. the doses of pregabalin 200 mg were not administered, on 3/22/2025, at 9:00 A.M. and 1:00 P.M. the doses of pregabalin 200 mg were not administered, on 3/23/2025, at 9:00 A.M., 1:00 P.M., and 5:00 P.M. the doses of pregabalin 200 mg were not administered, on 3/24/2025, at 9:00 A.M., 1:00 P.M., and 5:00 P.M. the doses of pregabalin 200 mg were not administered, and on 3/25/2025, at 9:00 A.M. the dose of pregabalin 200 mg was not administered. A review of the nurse's notes from 3/8/2025 to 3/25/2025 identified there was no documentation to reflect a provider was notified that Resident #11's pregabalin was not administered. Interview with MD #1 on 3/26/2025 at 12:14 P.M. indicated that APRN #1 had made him aware 'peripherally' that Resident #11 had missed some doses of pregabalin. MD #1 identified he had not been directly notified when Resident #11's pregabalin was not administered. MD #1 identified that he was not aware that from 2/12/2025 to 3/25/2025 Resident #11 had missed a total of 24 doses of pregabalin. MD #1 identified that if he had been directly notified, he could have ordered gabapentin (a medication used to treat nerve pain) as an alternative to pregabalin. Interview with the DNS (Director of Nursing) on 3/26/2025 at 1:20 P.M. identified she was aware Resident #11 missed 3 doses of pregabalin 200 mg during the month of February 2025 and 21 doses of pregabalin 200 mg during the month of March 2025. The DNS identified that when a medication is unavailable the nurse is to notify a provider and write a nurse's note to document the outcome of the notification. The DNS identified when Resident #11's pregabalin 200 mg medication was not available on various dates during February and March 2025, the nurse on duty should have notified the provider and wrote a nurse's note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with APRN #1 on 3/27/2025 at 9:35 A.M. identified that Resident #11 was prescribed pregabalin 200 mg to treat chronic pain and neuropathic pain. APRN #1 indicated on 2/24/2025 she wrote a prescription, directing to administer pregabalin 200 mg three times per day, which was faxed to the pharmacy. APRN #1 identified she was not notified from 2/12/2025 to 3/25/2025 that Resident #11's pregabalin was unavailable and was not administered per the physician's order. APRN #1 identified if she was notified, she would have ordered gabapentin as a substitute for the pregabalin. APRN #1 identified that she expects that if a resident's medication is not available, she is notified. Review of the facility change in condition policy; in part, identified when there is a significant change in the condition of the resident's physical, mental, or emotional status the resident's attending physician or medical director or his covering associate shall be notified.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, and interviews for one of three sampled residents (Resident #1) reviewed for admission to the facility, the facility failed to admit a resident that was already accepted and did not deny the resident admission after the resident arrived at the facility. The findings include: Resident #1's diagnoses included acute respiratory failure, acute decompensated heart failure, and moderate malnutrition. The Inter-Agency Patient Referral Report (W-10) dated 3/1/25 at 5:24 PM identified Resident #1 was alert and oriented, required assistance with most Daily Living Activities (ADLs), was identified as a high fall risk, and had a physician order that directed Resident #1 to be transferred to a long-term care (LTC) facility on 3/1/24 for skilled nursing services following hospitalization. The Emergency Medical Services (EMS) report dated 3/1/25 identified Resident #1 was transferred to the facility from an acute care hospital, transferred from the stretcher into a bed, a Registered Nurse was notified, and care was transferred to the LTC facility staff on 3/1/25 at 8:43 PM. The Prehospital Care Report dated 3/2/25 identified EMS was dispatched at 9:17 AM to a private residence for complaints of an individual having difficulty breathing. The report identified Resident #1 explained he/she had been admitted to the hospital a few days ago for pneumonia and congestive heart failure and then was discharged for rehabilitation to a LTC facility. The report indicated Resident #1 explained he/she could not be accepted by the facility due to not having paperwork from the hospital, and Resident #1 had to go to his/her residence. The report identified Resident #1 was not in respiratory distress. Hospital documentation dated 3/2/25 identified the case manager left a message at the LTC at 8:10 AM with a return call from the LTC facility at 8:18 AM. The case manager's note indicated when inquired as to what happened with Resident #1 being admitted to their facility last night, 3/1/25, the facility staff member state My bad on this one, you know it was after 4:00 PM. The note identified Resident #1 explained he/she was escorted out of the LTC facility, it was ten (10) degrees. The note identified Resident #1 would be transferred to another LTC facility. Interview with the Administrator on 3/17/25 at 10:41 AM identified Resident #1 arrived to the facility on 3/1/24 during the 3PM-11PM shift by ambulance from an acute care hospital for admission to the facility, was not able to be admitted because documentation for Resident #1 was not received, and Resident #1 left the facility around 12:00 AM on 3/2/25 to his/her residence. The Administrator indicated the facility was not aware Resident #1 was going to be admitted on [DATE], however the facility found out the following day on 3/2/25 from Admissions that Resident #1 was supposed to be admitted to the facility on [DATE]. The Administrator identified the facility had a centralized admissions process and the policy was for the facility to receive an update from admissions regarding pending admissions to the facility through a dashboard in the electronic medical record system, receive an admission notice through email, and receive a copy of the Inter-Agency Patient Referral Report (W-10) and hospital discharge summary for admission. (continued on next page)

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Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the 3PM-11 PM Nursing Supervisor, Registered Nurse (RN) 1, on 3/17/25 at 11:20 PM identified he was the nursing supervisor on 3/1/25 and the person responsible for completing new admissions. RN #1 indicated he was not notified prior to Resident #1's arrival to the facility that Resident #1 was to be admitted to the facility on [DATE] and facility policy was for staff to be notified of a pending admission prior to arrival. RN #1 identified upon Resident #1's arrival to the facility, the Inter-Agency Patient Referral Report (W-10) and hospital discharge summary was received from the ambulance personnel, and Resident #1 was placed in an available room. RN #1 identified since Resident #1 did not show up in the facility's electronic medical record system, he was unable to document the admission and informed the Director of Nursing (DON) and Administrator of the situation. RN #1 identified Resident #1 was not admitted to the facility on [DATE] because there was no paperwork on Resident #1 and he thought the reason for this was because Resident #1 was transported to the wrong facility. RN #1 indicated he called the ambulance to transfer Resident #1 back to the hospital, Resident #1 refused to go back to the hospital, and he was instructed by the DON to call the police when Resident #1 refused to leave the facility. RN #1 identified Resident #1, who was alert and oriented, left the facility to return home since Resident #1 was not able to be admitted to the facility. RN #1 indicated he did not obtain report from the hospital prior to Resident #1's arrival, did not contact the hospital after Resident #1 arrived, and indicated the DON was the person responsible for communication with the hospital on 3/1/25 following Resident #1's arrival at the facility. In an interview with the Regional Director of Nursing (DON) on 3/17/25 at 12:11 PM she identified she was the interim DON during the time of the incident. The Regional DON identified she was contacted on 3/1/25 at 10:30 PM, informed Resident #1 had arrived at the facility via ambulance for admission, and thought Resident #1 was at the wrong facility since Resident #1 was not in the facility's system, no admission notice was received, and the hospital did not call to give report prior to Resident #1's arrival. The Regional DON indicated she contacted facility admissions and spoke with the hospital to find out more information following Resident #1's arrival and was informed at 12:00 AM on 3/2/25 that there was a misunderstanding and Resident #1 was supposed to be admitted to the facility on [DATE]. The Regional DON identified she was informed Resident #1 had already left the facility because Resident #1 wanted to go home, and she then called Resident #1 and asked Resident #1 to return to the facility. Interview with the Medical Director on 3/27/25 at 9:35 AM identified he expected to be notified by a phone call or text message of an admission to the facility, at any hour during the day or night. The Medical Director indicated he should be notified if a resident was not able to be admitted for any reason. The Medical Director identified although he was not working the weekend of 3/1/25, the expectation was for him or the on-call provider to be notified prior to Resident #1 leaving the facility on 3/1/25. The Medical Director indicated no communication was received by the facility to inform him of the issue with Resident #1's admission until after Resident #1 left the facility. A follow-up interview with the Regional DON on 3/27/25 at 10:25 AM indicated she did not contact the Medical Director or the on-call provider prior to Resident #1 leaving the facility and was not aware Resident #1 arrived to the facility with a W-10 and hospital discharge summary. (continued on next page)

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Admissions Coordinator on 3/27/25 at 11:08 AM identified facility policy was for the Admissions Department to notify a facility of all pending admissions by sending an email directly to the center (facility) and by posting a notification to the center's (facility's) dashboard in the electronic system. The Admissions Coordinator identified information for pending admissions was put into the electronic system, which was called a lead, for anyone expected to be admitted and then had to be what was termed waitlisted in the system, in order for the facility to see the pending admission on the system dashboard. The Admissions Coordinator identified the lead for Resident #1 was created in the system on 3/1/25 and Resident #1 was expected to be admitted to the facility on [DATE]. The Admissions Coordinator indicated the reason for this was because of employee error. The Admissions Coordinator indicated admission Staff #1 was responsible for sending the notification to the facility on 3/1/25 and was unsure why it was not done. The Admissions Coordinator indicated she was the identified contact for any admission-related issues outside of business hours on 3/1/25, between 4PM-8AM, and expected to receive a call or text from the facility with any issues related to a pending admission during that timeframe. The Admissions Coordinator identified she received an email from the facility Administrator, which was sent on 3/1/25 at 9:00 PM, however she did not read the email until after midnight on 3/2/25. The Admissions Coordinator identified had she got a call or a text, she would have gotten the notification sooner and addressed the issues, and identified there was no facility process in place prior to the incident on the method to contact the identified on-call admissions contact after business hours.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #11) reviewed for medication administration, the facility failed to ensure the resident was administered medication according to provider order which resulted in medication omissions over a 6-week period (24 missed doses). The findings include: Resident #11 had diagnoses that included chronic pain, low back pain, pain in the right knee, and neuropathic pain. A provider's order dated 2/1/2025 directed to administer pregabalin (a medication used to treat nerve pain) oral capsule 200 milligram (mg) three times a day at 9:00 A.M., 1:00 P.M., and 5:00 P.M. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, was continent of bowel and bladder, independent with ADLs, transfers, and ambulation. The MDS further identified Resident #11 had frequent pain and received scheduled and as needed pain medication. Review of Resident #11's Controlled Substance Disposition log dated 2/12/2025 identified that the facility received thirty (30) capsules of pregabalin 200 mg from the pharmacy (10-day supply). Review of Resident #11's February 2025 Medication Administration Record (MAR) identified that on 2/12/2025, at 9:00 A.M. pregabalin 200 mg was not administered, on 2/24/2025, at 9:00 A.M. pregabalin 200 mg was not administered, and on 2/25/2025, at 9:00 A.M. pregabalin 200 mg was not administered. From 2/12/2025 to 2/25/2025 a total of 3 doses were not administered. Review of Resident #11's Controlled Substance Disposition log dated 2/25/2025 identified the pharmacy label on the disposition record directed to administer pregabalin 200 mg at bedtime for constipation. The Controlled disposition log identified the facility received thirty (30) capsules of pregabalin 200 mg from the pharmacy. Review of Resident #11's March 2025 Medication Administration Record (MAR) identified that on 3/8/2025, at 9:00 A.M. pregabalin 200 mg was not administered, on 3/9/2025, at 9:00 A.M. and 1:00 P.M. pregabalin 200 mg was not administered, on 3/10/2025, at 9:00 A.M., 1:00 P.M., and 5:00 P.M. pregabalin 200 mg was not administered, and on 3/11/2025, at 9:00 A.M. and 1:00 P.M. pregabalin 200 mg was not administered. From 3/8/2025 to 3/11/2025, a total of 8 doses were not administered. Review of Resident #11's Controlled Substance Disposition log dated 3/11/25 identified that the facility received twelve (12) capsules of pregabalin 200 mg from the pharmacy (4-day supply). Review of Resident #11's Controlled Substance Disposition log dated 3/15/25 identified that the facility received twelve (12) capsules of pregabalin 200 mg from the pharmacy (4-day supply). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's March 2025 Medication Administration Record (MAR) identified that on 3/18/2025, at 1:00 P.M. pregabalin 200 mg was not administered, on 3/20/2025, at 1:00 P.M. pregabalin 200 mg was not administered, on 3/21/2025, at 9:00 A.M. and 1:00 P.M. pregabalin 200 mg was not administered, on 3/22/2025, at 9:00 A.M. and 1:00 P.M. pregabalin 200 mg was not administered, on 3/23/2025, at 9:00 A.M., 1:00 P.M., and 5:00 P.M. pregabalin 200 mg was not administered, on 3/24/2025, at 9:00 A.M., 1:00 P.M., and 5:00 P.M. pregabalin 200 mg was not administered, and on 3/25/2025, at 9:00 A.M. pregabalin 200 mg was not administered. From 3/18/2025 to 3/25/2025, a total of 13 doses were not administered Review of Resident #11's Controlled Substance Disposition log dated 3/25/25 identified that the facility received ninety (90) capsules of pregabalin 200 milligram from the pharmacy (30-day supply). Interview with MD #1 on 3/26/2025 at 12:14 P.M. identified he directed treatment of Resident #11's chronic and neuropathic pain with prescribed pregabalin. MD #1 identified he directed that Resident #11 was to be administered pregabalin (Lyrica) 200 mg three times per day for neuropathic pain. MD #1 indicated he believed the reason Resident #11 missed doses of pregabalin was due to the pharmacy not having the supply of pregabalin. MD #1 identified when Resident #11's pregabalin was not available during the months of February and March 2025 an alternate medication gabapentin (medication used to treat nerve pain) could have been ordered to substitute Resident #11's doses of pregabalin. MD #1 was unable to explain why gabapentin was not ordered as a substitute for Resident #11 when pregabalin was not available. Interview with the DNS (Director of Nursing) on 3/26/2025 at 1:20 P.M. identified she was aware Resident #11 missed 3 doses of pregabalin 200 mg during the month of February 2025 and 21 doses of pregabalin 200 mg during the month of March 2025. The DNS indicated she thought the omissions from 2/12/2025 to 3/25/2025 were due to the pharmacy not having the supply of pregabalin. The DNS identified that upon further investigation she discovered the problem with Resident #11's pregabalin supply was caused on 2/24/2025 when an incorrectly written prescription was sent to the pharmacy directing to administer one capsule of pregabalin 200 mg orally at bedtime for constipation. The DNS was unable to identify who sent the prescription on 2/24/2025. The DNS identified on 2/25/2025 the pharmacy delivered 30 capsules of pregabalin for Resident #11 which was only a 10-day supply. The DNS indicated refills were attempted numerous times; however, the pharmacy could not refill the prescription because it was identified as too soon by the pharmacy. The DNS indicated on 3/25/2025, the supply problem for Resident #11's pregabalin 200 mg medication, was resolved. Review of Resident #11's Controlled Substance Disposition log dated 3/25/25 identified that the facility received 90 capsules of pregabalin 200 mg. Interview with APRN #1 on 3/27/2025 at 9:35 A.M. identified on 2/24/2025 she wrote a prescription for Resident #11 that directed to administer pregabalin 200 mg orally three times per day. APRN #1 indicated that Resident #11 was prescribed pregabalin 200 mg for chronic pain and neuropathic pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Pharmacist #1 on 3/27/2025 at 9:55 A.M. identified on 2/24/2025 a prescription was faxed to the pharmacy directing to administer pregabalin 200 mg once per day at bedtime for constipation. Pharmacist #1 identified when the pharmacy received the prescription, the pharmacist should have questioned the order, but did not, and the medication was delivered to the facility on 2/25/2025. Pharmacist #1 indicated the prescription directions caused issues when the facility attempted to re-order the pregabalin on 3/6/2025, 3/7/2025, 3/9/2025, 3/11/2025 and 3/25/2025. Pharmacist #1 identified there had been a supply issue with pregabalin, however, the pharmacy had been able to provide Resident #11's pregabalin 200 mg capsules as ordered. Pharmacist #1 identified on 3/25/2025, when the prescription was corrected, the pharmacy delivered a 30-day supply of Resident #11's pregabalin 200 mg capsules. Although requested, documentation of Resident #11's written or electronic pregabalin prescriptions for February and March 2025, which were sent to the pharmacy, were not provided. Review of the facility medication administration policy; in part, identified if a medication is not available at the time of administration notify the physician immediately and request guidance or an alternative order, check with the pharmacy or alternate suppliers to expedite delivery of the medication, and document all actions taken in the resident's medical record and notify the supervisor.