STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075300	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Shelton Lakes	5 Lake Road Shelton, CT 06484

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for change in condition, the facility failed to facilitate the inclusion of the resident and/or resident representative in the development and implementation of his or her person-centered plan of care. The findings include: Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for change in condition, the facility failed to facilitate the inclusion of the resident and/or resident representative in the development and implementation of his or her person-centered plan of care. The findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, and depression. Record review identified Person #1 was Resident #2's responsible party, Power of Attorney, and substitute decision maker. The Resident Care Plan (RCP) dated 2/1/2023 identified Resident #2 had a psychiatric diagnosis. Interventions directed family involvement with care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of six out of fifteen (6/15), indicative of severe impaired cognition and was dependent with personal care. Record review failed to identify any interdisciplinary team (IDT) meetings were conducted from admission during 1/2023 through 4/19/2023. Although requested, the facility was unable to provide any documentation that any IDT meetings were conducted from admission during 1/2023 through 4/18/2023. A social services note dated 4/19/2023 at 10:21 AM, written by Social Worker (SW) #1 identified a telephone care plan meeting was held on 4/19/2023 with Person #1. Review of the IDT Care Plan Meeting document dated 4/21/2023 without a time frame noted, identified the care plan meeting was attended by Person #1, the Recreation Director, Dietary Director, and SW #1. The document failed to identify if Resident #2 or Person #1 were present during the meeting, or if they were invited. Interview with RN #1 and the Administrator on 9/2/2025 at 2:25 PM identified the facility performs a baseline and comprehensive care within seven (7) days of admission to the facility. The facility then holds an IDT care plan meeting within twenty-one (21) days from admission, and then quarterly meetings thereafter. RN #1 and the Administrator were unable to provide documentation that an admission care plan meeting was held within seven (7) days of admission to the facility on 1/27/2023, or any additional care plan meetings before 4/19/2023. RN #1 and the Administrator stated the facility should have conducted the meetings as described and should have included both Resident #2 and Person #1, and were unable to explain why that did not occur. Review of the facility Care Plan Policy dated 10/30/20 directed in part, the resident and/or family/responsible party will be invited to attend all care plan conferences. Further, the Policy directed a comprehensive care plan will be developed in collaboration with the resident and/or family/responsible party. A Care Conference to discuss the plan of care will be held on or before day twenty-one (21) from admission and then at least quarterly.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE