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	12/10/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 resident (Resident #1) reviewed for ADLs, the facility failed to ensure a resident that required assistance with showers was offered or provided showers at least once a week in accordance with the plan of care. The findings include: Resident #1's diagnoses included dementia, cerebral infarction (stroke) and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of five out of fifteen (5/15), indicative of severe cognitive impairment, ambulated independently and required set-up assistance for showers. The Resident Care Plan dated 10/12/2025 identified Resident #1 required assistance with ADLs. Interventions directed Resident #1's ability to perform ADLs may fluctuate due to cognitive status, set up and allow to do for self as able, and directed to assist with ADLs as needed. Review of Resident #1's care card identified he/she was scheduled to receive a shower on Thursdays during the 7:00 AM to 3:00 PM shift. The care card further identified Resident #1 was independent with bathing and preferred showers. Review of the shower/bathing documentation for the period of September 2025 through November 2025 revealed out of nine (9) weekly opportunities, only two (2) dates (10/30 and 11/1/2025) identified Resident #1 received a shower. Documentation for seven (7) remaining scheduled shower days lacked any indication that a shower was provided or was refused. Additional clinical record review failed to identify documentation to indicate Resident #1 refused showers during the seven (7) dates scheduled (September through November), nor documentation that showers were rescheduled or that alternative hygiene measures were provided.Interview with the DON on 12/10/2025 at 12:50 PM identified if a resident refuses to take a shower, the nursing staff should always re-attempt at a different time or the following day after the refusal. Additionally, the nursing assistants (NAs) should notify the resident's nurse. The DON stated she was not aware of any complaints regarding showers, or lack of showers from the resident, conservator, or family. The DON stated showers are documented in the electronic charting system (Point Click Care - PCC), and if the shower was not documented to indicate it was given or refused, then it was considered staff did not provide the shower; it was not performed. Review of the undated facility Bathing/Shower Policy directed each resident will be offered a full bath/shower at least weekly. The nursing staff will assist in preparing the shower for a resident and ensure safety throughout the process.

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