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	05/20/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **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 #1) reviewed for discharge, the facility failed to maintain resident privacy when they discharged a resident with his/her roommate's medication labeled with the resident name and drug name. The findings include: Resident #1's diagnoses included Alzheimer's, urinary tract infection, and diabetes. The discharge Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen, indicative of severe cognitive impairment and was dependent for ADLs, and required assistance with ambulation. The Resident Care Plan (RCP) dated 2/9/2026 identified admitted for short term rehabilitation. Interventions directed to establish a discharge plan and arrange for home care services, social services will facilitate discharge planning when appropriate and arrange for any equipment needed at home. 2. Resident #2's diagnoses included dementia, anxiety and restlessness and agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a BIMS score of three out of fifteen, indicative of severe cognitive impairment and had a psychiatric/mood disorder. A physician order (for Resident #2) dated 3/2/2026 directed Quetiapine Fumarate (Seroquel - antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depressive disorder) Oral Tablet 50 milligrams (mg), give two (2) tablets one time a day for mood disorder. Review of facility census identified Resident #1 and Resident #2 were located on the same unit and shared the same resident room (were roommates). Nursing note dated 3/31/2026 at 2:13 PM, written by the DNS indicated Resident #1 was discharged to home at 2 PM with his/her family member. The family member signed the discharge paperwork, and Resident #1 was assisted into car by staff member. Social service note dated 4/2/2026 at 15:40 (3:40 PM) identified Resident #1 was discharged to home on 3/31/2026 and the discharge plan was reviewed with the spouse who reported understanding. No concerns noted at the time of discharge. Review of facility Accident and Investigation report dated 4/1/2026 identified Resident #1 was discharged to home on 3/31/2026, and on 4/1/2026 the facility received a call from a family member who reported Resident #1 took the wrong medication and was lethargic. The facility APRN was notified of the error after being discharged home, and the APRN advised to send Resident #1 to the hospital for evaluation. The facility initiated an investigation. Record review identified Resident #1 was not prescribed Quetiapine Fumarate (Seroquel). Review of facility Medication Error Report dated 4/1/2026 identified a medication error occurred on 3/31/206 at 10:30 AM. Resident #1 was sent home with someone else's medications (at discharge). The error reason indicated: the nurse overlooked the medications and the actual error was made by the family member. The family called to report the error. The report identified to prevent future occurrences the plan was to check medications twice before handing them to a patient. Record review identified a statement by LPN #1 indicated she did not check the medications given to Resident #1's family member at the time of discharge. The statement indicated she should have checked the medications. Interview and record review with Home Care Nurse (HCN) #1 on 5/19/2026 at 1:23 PM identified she visited Resident #1 on 4/1/2026 and identified Resident #1 was not lucid and dozing off. The family member indicated Seroquel was given to patient, and Emergency Medical Services were called. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medications discharged with Resident #1 identified a blister card labeled Seroquel. The blister card of Seroquel had another patient/resident's name on the pack, and the family member had stated he/she gave the Seroquel the night before. On 5/20/2026 at 10:20 AM interview and record review with LPN #1 identified that on 3/31/2026 she was assigned Resident #1, though she typically did not work on that shift or that unit, Resident #1 was scheduled to be discharged to home and a family member came to the facility to pick up Resident #1 for discharge to home. LPN #1 indicated she gathered Resident #1's medication blister packs out of the facility medication cart and was attempting to review the discharge instructions and medications when the family member was focused on finding resident's clothes and had several interruptions. LPN #1 stated Resident #1 was not on Seroquel, however when she later learned Resident #1 had been sent home with Seroquel, it was identified that Resident #1's roommate (Resident #2) was on Seroquel oral 50 mg, two (2) tabs at bedtime and that medication must have gotten mixed in with Resident #1's discharge medications. LPN #1 further indicated she should have double checked the medications she was sending home with Resident #1. Interview and record review on 5/20/2026 at 12:53 PM with the DNS identified when staff discharge a resident, the nurse should review the discharge instructions and review the medications being sent home with the resident. The DNS further stated the nurse is responsible to ensure the person being provided the education is attentive/focused on the directions provided. The family had indicated the Seroquel blister pack was labeled with Resident #2's name. Medications are stored in the medication cart by room number and Resident #2's Seroquel was likely picked up in error; Resident #2's medications should not have been sent with Resident #1. Review of the facility Resident Rights Policy directed in part, residents have the right to privacy and confidentiality regarding all personal and health information kept by the facility, as provided by federal and state laws governing the facility's use and disclosure of this information.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 #1) reviewed for discharge, the facility failed to ensure the resident medications were reviewed prior to discharge to ensure the correct medications were sent with the resident upon discharge to the community to prevent a medication error. The findings include: 1. Resident #1's diagnoses included Alzheimer's, urinary tract infection, and diabetes. The discharge Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen, indicative of severe cognitive impairment and was dependent for ADLs, and required assistance with ambulation. The Resident Care Plan (RCP) dated 2/9/2026 identified admitted for short term rehabilitation. Interventions directed to establish a discharge plan and arrange for home care services, social services will facilitate discharge planning when appropriate and arrange for any equipment needed at home. 2. Resident #2's diagnoses included dementia, anxiety and restlessness and agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a BIMS score of three out of fifteen, indicative of severe cognitive impairment and had a psychiatric/mood disorder. A physician order (for Resident #2) dated 3/2/2026 directed Quetiapine Fumarate (Seroquel - antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depressive disorder) Oral Tablet 50 milligrams (mg), give two (2) tablets one time a day for mood disorder. Review of facility census identified Resident #1 and Resident #2 were located on the same unit and shared the same resident room (were roommates). Nursing note dated 3/31/2026 at 2:13 PM, written by the DNS indicated Resident #1 was discharged to home at 2 PM with his/her family member. The family member signed the discharge paperwork, and Resident #1 was assisted into car by staff member. Social service note dated 4/2/2026 at 15:40 (3:40 PM) identified Resident #1 was discharged to home on 3/31/2026 and the discharge plan was reviewed with the spouse who reported understanding. No concerns noted at the time of discharge. Review of facility Accident and Investigation report dated 4/1/2026 identified Resident #1 was discharged to home on 3/31/2026, and on 4/1/2026 the facility received a call from a family member who reported Resident #1 took the wrong medication and was lethargic. The facility APRN was notified of the error after being discharged home, and the APRN advised to send Resident #1 to the hospital for evaluation. The facility initiated an investigation. Review of facility investigation statement written by the DNS, dated 4/1/2026, indicated the family member called and reported Resident #1 was lethargic. The family member stated medications were given to Resident #1 and after the mediation was administered he/she realized the medication was not for Resident #1. The family member reported that he/she had given Resident #1 two (2) tablets of Seroquel. The statement indicated the family member was advised the Seroquel was not prescribed for Resident #1 and to take Resident #1 to the hospital for evaluation. Plan for facility social worker to update home care agency that Resident #1 was referred to the hospital. Review of social worker investigation statement dated 4/1/2026 indicated she received call from former Resident #1's family member, lethargic, difficult to arouse, and stated Resident #1 had taken the wrong medication. Advised to call 911 and take to emergency room (ER). SW called the home care agency and notified them of the incident. Review of home care agency note dated 4/1/2026, identified former Resident #1 was not admitted to home care service due to the wrong medication was given to the patient on last night 8 PM, Seroquel 100 mg. The (home care agency) RN assessed the patient sleeping on the couch, vital signs were normal, was not speaking and was very lethargic. A call was placed to 911, EMS (Emergency Medical Services) arrived at 12:15 PM and transferred to the ER. EMS run sheet dated 4/1/2026 indicated dispatched for prescription mistake, found patient sitting in a chair inside the home, in care of family and home health nurse. The patient was alert but confused, as normal for level of dementia, not showing (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obvious signs of distress. Family member stated gave the patient the wrong medication last night, and patient was more lethargic than normal. Review of facility Medication Error Report dated 4/1/2026 identified a medication error occurred on 3/31/206 at 10:30 AM. Resident #1 was sent home with someone else's medications (at discharge). The error reason indicated: the nurse overlooked the medications, and the actual error was made by the family member. The family called to report the error. The report identified to prevent future occurrences the plan was to check medications twice before handing them to a patient. Record review identified Resident #1 was not prescribed Quetiapine Fumarate (Seroquel). Record review identified a statement by LPN #1 indicated she did not check the medications when they were given to Resident #1's family member at the time of discharge. The statement indicated she should have checked the medications. Interview on 5/19/2026 at 8:40 AM with Home Care Supervisor (HCS #1) identified during a visit on 4/1/2026 Resident #1 was lethargic and had taken the wrong medication (took Seroquel that belonged to another resident). HCS #1 stated Resident #1 was subsequently admitted to the hospital. Interview and record review with Home Care Nurse (HCN) #1 on 5/19/2026 at 1:23 PM identified she visited Resident #1 on 4/1/2026 and identified Resident #1 was not lucid and dozing off. The family member indicated Seroquel was given to patient, and Emergency Medical Services were called. Review of medications discharged with Resident #1 identified a blister card labeled Seroquel. The blister card of Seroquel had another patient/resident's name on the pack, and the family member had stated he/she gave the Seroquel the night before. On 5/20/2026 at 10:20 AM interview and record review with LPN #1 identified that on 3/31/2026 she was assigned Resident #1, though she typically did not work on that shift or that unit, Resident #1 was scheduled to be discharged to home and a family member came to the facility to pick up Resident #1 for discharge to home. LPN #1 indicated she gathered Resident #1's medication blister packs out of the facility medication cart and was attempting to review the discharge instructions and medications when the family member was focused on finding resident's clothes and had several interruptions. LPN #1 stated Resident #1 was not on Seroquel, however when she later learned Resident #1 had been sent home with Seroquel, it was identified that Resident #1's roommate (Resident #2) was on Seroquel oral 50 mg, two (2) tabs at bedtime and that medication must have gotten mixed in with Resident #1's discharge medications. LPN #1 further indicated she should have double checked the medications she was sending home with Resident #1. Interview and record review on 5/20/2026 at 12:53 PM with the DNS identified when staff discharge a resident, the nurse should review the discharge instructions and review the medications being sent home with the resident. The DNS further stated the nurse is responsible to ensure the person being provided the education is attentive/focused on the directions provided. The family had indicated the Seroquel blister pack was labeled with Resident #2's name. Medications are stored in the medication cart by room number and Resident #2's Seroquel was likely picked up in error; Resident #2's medications should not have been sent with Resident #1. Review of facility Medication & Discharge Safety Education Nursing Responsibility for Safe Practice The 5 Rights of Medication Administration directed in part, the 5 Rights of a Safe Discharge - Right Patient: verify using three (3) identifiers, Right Medication: ensure only correct medications are sent, Right instructions: provide clear instructions and use teach-back, Right Documentation: ensure all paperwork is complete, Right Handoff: communicate with receiving caregiver/facility. Sending a resident home with another resident's medication is a serious medication error and a HIPAA (Health Insurance Portability and Accountability Act) violation of sharing PHI (Personal Health Information). Always double check medications prior to discharge.