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	12/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 2 of 3 sampled residents (Resident #28 and Resident #32) reviewed for resident rights, the facility failed to ensure a resident(s) with a urinary collection device was treated in a dignified manner. The findings include: 1. Resident #28's diagnoses included obstructive and reflux uropathy and other disorders of the prostate. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 as moderately cognitively impaired and required (1) to (2) assist with Activities of Daily Living (ADL). The Resident Care Plan (RCP) dated 11/12/24 identified Resident #28 had an indwelling urinary device in place. Interventions directed provide catheter care as ordered, change drainage bag as ordered and provide privacy cover for drainage bag. The physician's orders dated 11/13/24 directed catheter care every shift and apply leg bag when out of bed. An observation with the Director of Nursing Services (DNS) on 12/02/24 at 10:58 AM identified Resident #28 in a johnny coat sitting in a wheelchair next to her/his bed with urine collection tube extending out from between h/her legs to a urine collection device full of tea colored urine in a basin on the floor beside h/her and without the benefit of a privacy cover. Resident # 28 was sitting closest to the entry room door, with the door open, no privacy curtain with full view of any visitors/staff passing by to his/her roommate. An interview with the DNS on 12/02/24 at 10:58 AM identified she was unaware of any privacy cover required for urine collection devices for any resident while in their room. The DNS further identified Resident #28 should have the urinary collection tubing switched to a leg bag if s/he left the room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Shelton Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 5 Lake Road Shelton, CT 06484	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with Nurse Aide (NA #10) on 12/04/24 at 2:45 PM identified he was assigned to Resident #28 on 12/2/24 during the 7:00 AM to 3:00 PM shift and well known to him/her. NA #10 identified he routinely left the urine collection device in basin directly on the floor next to Resident #28. NA #10 further identified he was instructed earlier in the day by the DNS to connect the urinary collection tubing to a leg bag for privacy (subsequent to surveyor inquiry). A review of the facility policy for Resident Rights (no date) directed that each resident had the right to be treated with consideration, full respect and full recognition of dignity and individuality. A review of the facility policy for Catheter Care dated 9/30/22 directed that for any resident with a urinary collection device, a privacy bag or fig leaf bag be provided to ensure dignity and using a large drainage closed system bag. 2. Resident #32 's diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms, Methicillin Resistant Staphylococcus Aureus Infection and Chronic Obstructive Pulmonary disease (COPD). A physician's order dated 1/18/24 directed to Change Foley Catheter Bag ever week and as needed. The care plan dated 9/23/24 identified Foley. Interventions included changing the catheter and bag as needed. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #32 as cognitively intact and required maximal assistance for toileting hygiene, bed mobility and personal hygiene. Observation on 12/03/24 at 9:50 AM of Resident # 32's Foley bag on the floor uncovered. Observation on 12/03/24 at 11:30 of Resident # 32 'Foley bag on the floor and uncovered. Interview with Registered Nurse (RN #5) on 12/03/24 at 11:35 AM indicated she was unsure of what the privacy bag was, therefore, she informed Resident #32's nurse to obtain a privacy bag. RN #5 noticed it was not done and stated nurses are responsible for ensuring Foley is covered and not on the floor. Facility Catheter Care policy dated 9/30/22 indicated in part that Privacy bag or fig leaf bag to ensure dignity. 49100

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations of the environment, review of facility policy and interviews, the facility failed to maintain a safe, clean homelike environment. The findings included: 1. An observation on 12/02/24 at 10:45 AM identified the following: a) room [ROOM NUMBER] Discolored and stained toilet seat. Stained tile and walls around toilet. b) room [ROOM NUMBER] Marred walls. c) room [ROOM NUMBER] - stained [NAME] in the bathroom, marred walls. d) room [ROOM NUMBER] marred closet door, large amount of brown staining on curtain next to bed #1. e) room [ROOM NUMBER]- Marred walls, exposed sheetrock next to bed #1. f) room [ROOM NUMBER]- Large smeared brown stain above garbage in front of bed #2, missing closet baseboard rusted commode seat, brown dried stain drops along wall. g) room [ROOM NUMBER]- Rusted metal trim in bathroom, brown buildup in corners and on side of closet in front of bed #1. Stained toilet seat. h) room [ROOM NUMBER]- Marred walls, hole in sheetrock next to bed #1, discolored and stained toilet seat, screw holes under soap dispenser, unpainted sheetrock next to entry door with screw holes, marred closet door and sides. i)room [ROOM NUMBER]-Marred walls along baseboard. A subsequent observation and interview with the Director of Maintenance on 12/09/24 at 10:10 AM identified he was responsible for the oversight of maintenance and housekeeping staff to identify and address environmental cleanliness and damage in resident occupied areas. This is typically accomplished through environmental rounds and as identified by the interdisciplinary team. The Director of Maintenance further identified environmental concerns were being addressed annually and in a going manner but was unable to provide supporting documentation/environmental rounds that detailed the plan for completion for some of some of the environmental concerns, i.e. toilet set cover, replacement molding. The Director of Maintenance further identified housekeeping staff should be addressing the cleanliness in an ongoing manner. An interview with the Administrator on 12/09/24 at 10:10 AM identified she would expect the environment be maintained in a safe, clean and sanitary manner. Although requested, a policy for maintaining a clean environment was not provided. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the facility policy for Infection Control Surveillance and Safety Rounds dated 1/2/23 directed surveillance rounds tube conducted on a regular basis by the infection control nurse/designee. Each department head will be responsible for correcting issues identified during the surveillance process and document these corrections on the surveillance rounds form. 2. Concerns were received by the state agency online reporting system on 1/5/2024. Concerns noted the facility had stained ceiling tiles and mold in the ceiling registers. On 12/4/24 at 9:35 AM a tour of the facility identified scattered stained tiles. In the chapel, near the back door, a cracked ceiling tile was observed to be tapped. In the resident lounge that housed a small piano and located off of the hallway leading to the long term care wing, a stained tile by the window and exit door was observed. In the hallway directly outside of room [ROOM NUMBER] three ceiling tiles were observed to be stained. No black staining nor black substances were observed on the ceiling or on ceiling registers. The state agency Building Fire and Safety inspection team also conducted its own inspection and found no indication of mold, but did indicate scattered stained tiles in resident areas. The infection control surveillance and safety rounds policy indicated that each department head will be responsible for correcting issues identified during the surveillance process. 48880

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, review of facility policy, and interviews for 1 of 1 resident reviewed for Hospice/ End of Life (Resident #154), the facility failed to ensure the care plan was revised when the resident elected Hospice/ End of Life services. The findings included: 1. Resident #154's diagnoses included dementia and arteriosclerotic heart disease. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #154 did not receive Hospice/ End of Life services and did not have a prognosis of 6 months or less. A nursing progress note dated 11/23/2024 at 12:21 PM indicated in part Resident #154 was admitted to hospice care effective 11/23/2024. An interview and record review on 12/6/2024 at 10:00AM with the MDS Coordinator (RN #3) identified the Social Worker (SW) is responsible for residents on Hospice, and if no care plan was noted when completing the Significant Change MDS assessment. RN #3 would initiate a hospice care plan at the time of the Significant Change MDS . An interview and clinical record review with SW#1 on 12/6/2024(14 days after hospice election) at 10:34 AM indicated she did not find a Hospice care plan for Resident #154 in the resident record. SW# 1 further indicated the care plan would have been written by the MDS Coordinator and indicted a care plan should have been added in the facility electronic documentation system . The facility policy labeled care planning indicated in part the care plan is updated at least quarterly and necessary to reflect the changes in the residents' status. 48792

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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** 49100 Based on clinical record review and staff interviews for 1 sampled resident (Resident #23) reviewed for edema, the facility failed to consistently conduct weights according to physician orders. The findings include: Resident #23 's diagnoses included Congestive Heart Failures (CHF), localized edema and type 2 diabetes mellitus. A physician's order dated 9/25/24 directed daily weight in AM one time a day for CHF. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #23 as cognitively impaired and requires supervision/ touching assistance with personal hygiene and maximal assistance with dressing and toileting hygiene. The Resident Care plan dated 10/18/24 identified CHF. Interventions directed to watch for any increased edema (lower extremities, abdomen, sacrum and generalized swelling) and to report to MD/ Advanced Practice Registered Nurse (APRN). Review of clinical record of Resident # 23's weight for daily weights for for months of October, November and December 2024 identified the following : The facility conducted 4 out of 8 daily weights for the month of December 2024 The facility conducted 7 out 30 daily weights for the month of November 2024 The facility conducted 14 out of 31 weights for the month of October 2024 Interview with RN #8 Assistant Director of Nursing Services (ADNS) on 12/9/24 at 9:23AM identified weights are only documented in the facility electronic records. The ADNS further explained, the first seven days of the month weights are collected on paper then documented in the electronic records under weights, Medication Administration Records (MAR) or Treatment Administration Records (TAR). The ADNS also identified if a resident refuses, the refusal would be documented in the progress notes. A follow up interview with the ADNS on 12/9/24 at 10:32 AM identified if the MAR or TAR is signed off, it reflects the work/ task was completed and indicated the expectation is that weight are documented. The charge nurse, ADNS and DNS are responsible for overseeing that signed off tasks are completed. however, the ADNS was unable to explain why daily weights were signed off as completed but not documented in the clinical record

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 5 of 5 sampled residents (Residents #16, #18, #23, #76 and #83) reviewed for quality of care, the facility failed to ensure residents receive proper treatement to maintain adequate hearing. The findings included: 1. Resident #16's diagnoses included dementia and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #16 as severely cognitively impaired and required two person assist with activities of daily living (ADL). The Resident Care Plan (RCP) dated [DATE] identified Resident #16 was hearing impaired, wore a hearing aid and refused at times. Interventions directed to offer hearing aids daily, offer audiology consult as needed and if resident refuses, offer at a later time and utilize family member if available. A social service progress note dated [DATE] identified per request of Resident #16 and responsible party, a contracted community specialty service was contacted and placed the resident on a list for an audiology visit on [DATE] for a hearing aid evaluation. An audiology consult dated [DATE] identified Resident #16 was evaluated after noting new verbal communication difficulties, such as having commands repeated, not turning when spoken to, having difficulty understanding speech with a request for hearing aids. Clinical findings identified hearing loss could not be established in both ears due to cerumen (ear wax) remaining in both ears after instrument removal. Recommendations were made for wax removal in both ears. A subsequent social service progress note dated [DATE] identified the contracted community specialty service was contacted, and Resident #16 was to be seen on the next visit for hearing aid evaluation per responsible party request. A review of the social worker progress notes, nursing progress notes and physician orders and facility documentation failed to reflect Resident #16 was treated and revaluated for hearing loss/hearing aids. An interview and clinical record review with Social Worker, SW #1 on [DATE] at 9:03 AM identified she was responsible for overseeing medical specialty services for the residents. SW #1 identified for any service; a request was sent with consent to the contracted service provider which would include requests for hearing aids. SW #1 submitted a request to the contracted service provider on [DATE] for [DATE] and again on [DATE] for the resident to be seen on [DATE]. SW #1 identified that she assumed it would be her responsibility to follow up on the provider requests but had not done so on behalf of Resident #16. SW #1 further identified she did not offer any alternative community services for audiology to Resident #16 or responsible party. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and facility documentation review with Person #1, the Customer Care Coordinator for the community service providers on [DATE] at 9:16 AM identified she coordinated specialty visits with the facility. Once a consent with request for services was received, the provider would request orders and clinical information for the resident. Following each facility visit, the Director of Nursing Services, DNS and SW #1 would receive an After Visit Summary detailing the treatment provided to each resident, and reason, if any, a resident was not seen. Person #1 identified Resident #16 was initially seen on [DATE] for audiology. Recommendations were made for wax removal which was included on the After Visit Summary sent to the DNS and SW #1. It was expected the facility contact the community provider once treatment was completed so the resident could be evaluated. Person #1 identified she had not been contacted by the facility at any time regarding the status of Resident #16's treatment and that audiology services had been provided to facility residents on (8) occasions between [DATE] and present. Person #1 further identified on [DATE], (21) scheduled residents were not seen due physician orders not being received prior to the appointment which was also detailed in the after-visit summary. Person #1 also indicated there have been ongoing issues with the facility in following recommendations for residents to be seen. An interview with the DNS on [DATE] at 11:06 AM identified she, in coordination with SW #1 and Assistant Director of Nursing Services oversaw community provider services. Once identified, a request with consent would be sent to the community provider to add the resident to a list to be seen at the next scheduled visit. Any clinical information and orders were to be obtained and sent to the provider prior to the visit. All information was communicated to her through email fax and phone calls from the provider. The DNS identified any recommendations should be reviewed by the APRN and that nursing staff should be following up on the status of the recommendations. The DNS further identified that although she received correspondence from the community provider, she was unaware there were any concerns related to residents not being seen, recommendations not being followed, and was unable to explain how the systemic issue occurred. An interview with the Administrator on [DATE] at 10:44 AM identified she would expect that if a resident required specialty services, orders are obtained, residents seen timely, recommendations followed, and the facility follow up on any resident not seen. 2. Resident # 18 's diagnoses included anxiety disorder, arteriosclerosis, and Adult Failure to Thrive, A physician's order dated [DATE] directed to provide Dental, Ophthalmology, Podiatry, and Audiology services as needed through Health Drive. The annual Minimum Data Set assessment dated [DATE]/24 identified Resident #18 as cognitively intact and dependent for toileting, personal hygiene, and lower body dressing. The care plan dated [DATE] identified Resident #18 required assistance with ADL. Interventions included assistance of 2 for care. Review of the facility contracted vendor documentation indicated Resident #18 refused services on [DATE] and was rescheduled for [DATE]. The contracted vendor documentation for [DATE] indicated they could not evaluate Resident #18 as they did not have a physician's order. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview with Administrator and DNS on [DATE] at 11:07 AM identified the contracted vendor appointments are initiated upon admission. The Resident/Family will sign a consent for contracted vendor services if they wish to receive services from them. The services will then be added to contracted vendor schedule. The resident will be seen by the next available date. The DNS, ADNS, and Social Worker are involved in the process. The facility is notified if more information is required prior to the appointment such as MD orders. The DNS will provide the information to contracted vendor. In an interview with the Administrator on [DATE] at 10:40 AM identified the expectation is that appointments are made timely and there is timely follow up. The DNS should be overseeing the process. 3. Resident #23 's diagnoses included dementia, and cataracts. A physician's order dated [DATE] directed for vision, dental, podiatry, audiology and psychiatric services as needed. A care plan dated [DATE] identified Resident #23 had difficulty understanding and/or expressing speech related to a decline in cognitive status. An attending physician's request for services/consultation dated [DATE] identified the family or staff had noticed recent decreased in the resident responsiveness and a request for an audiological consultation by the facility audiologist. The quarterly MDS assessment dated [DATE] identified Resident #23 as severely cognitively impaired and had adequate hearing and did not use a hearing aide. Facility documentation dated [DATE] identified that although Resident #23 was on the schedule to be seen by audiology, the resident was unable to be seen due to no physician's orders noted for treatment. A review of the medical record from [DATE] through [DATE] failed to identify if Resident #23 had been evaluated by an audiology specialist. On [DATE] at 2:44 PM an interview with the audiologist customer care representative (Person #2), indicated that a resident is placed on the schedule to be seen after the facility has submitted a request for services and every visit from audiology required a new physician's order. On [DATE] at 11:07 AM an interview with the Administrator and DNS identified that consents for the facility audiology specialty services are obtained on admission and signed by the resident or resident representative and requests for services are submitted when the resident is requesting to be seen or there is an issue that require an evaluation. The DNS was unable to indicate what had prompted a request for service on [DATE] and why there was no physician's order noted on [DATE]. Although, the DNS indicated she was responsible for following up on visit summaries from audiology services she was unable to indicate why follow ups were not being completed. Although the facility did not have an audiology policy for Consultation for Outside Medical Appointments which identified the facility must communicate the outcomes and recommendations from outside healthcare providers to the resident, family, and relevant staff. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #76 's diagnoses included hypertension, anxiety and Alzheimer disease. A physician's order dated [DATE] directed to have Vision, Dental, Podiatry, Audiology and Psychiatric Services as needed. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #76 as cognitively impaired and required supervision for eating and maximal assistance for oral and toileting hygiene. The care plan dated [DATE] identified Essential Support Person. Interventions included following facility policy and procedures for essential support persons. Resident's #76 on [DATE] care conference signs off sheet indicate nursing staff was not in attendance. Review of records indicated a recommendation from audiology visit from the facility contracted vendor for wax removal on [DATE]. Subsequent to recommendation on [DATE] there were no physician's order indicating to remove wax post recommendation. Interview with the DNS and Administrator on [DATE] at 11:15 AM indicated on admission residents and/or representative sign consents to receive treatment from facility contracted vendors for services. The DNS reported once recommendations are made, the APRN is informed and is responsible for following up with recommendations. The DNS indicated once the APRN is informed, the expectation is the APRN should follow up with recommendations in a timely manner. The DNS further identified it is her responsibility to ensure follows up appointments are followed through , however, she/he was unable to explain why this was not done. Facility Consultation for Outside Medical Appointments policy in part directed the facility is responsible for ensuring residents receive timely and coordinated care for outside medical appointments and to review instructions or recommendations provided by outside healthcare providers. 5. Resident #83's diagnoses included cerebral infarction (stroke) and dementia. The annual MDS assessment dated [DATE] identified Resident #83 as severely cognitively impaired and (1) to (2) person assist with ADL. The RCP dated [DATE] identified Resident #83 had progressive intellectual decline related to dementia and needed social interaction/mental stimulation. Interventions directed to assist as needed to meet needs and to offer activity supplies of preference/ interest including movies, music and offer social visits. An audiology consult dated [DATE] identified Resident #83 was being evaluated after family/staff noted recent deceased responsiveness. Hearing loss could not be evaluated as ear wax remained in both ears following instrument removal. Recommendations made for wax removal to the right ear. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the social worker progress notes, nursing progress notes and physician's orders and facility documentation failed to reflect Resident #16 was treated and revaluated for hearing loss/hearing aids. An interview and clinical record review with Social Worker, SW #1 on [DATE] at 9:03 AM identified she was responsible for overseeing medical specialty services for residents. SW #1 identified for any service; a request was sent with consent to the contracted service provider. SW #1 further indicated she assumed it was her responsibility to follow up on the provider requests but had not done so. An interview and facility documentation review with Person #1, the Customer Care Coordinator for the community service providers on [DATE] at 9:16 AM identified she coordinated specialty visits with the facility. Once a consent with request for services was received, the provider would request orders and clinical information for the resident. Following each visit the facility, the Director of Nursing Services (DNS) and SW #1 would receive an After Visit Summary detailing the treatment provided to each resident, and reason, if a resident was not seen. The expectation for not being seen would required the facility to contact the community provider once treatment was completed for a resident so the resident can be evaluated. Person #1 further identified on [DATE], (21) scheduled residents were not seen due physician orders not being received prior to the appointment which was also detailed in the after-visit summary. Person #1 further indicated there have been ongoing issues with the facility in following up on recommendations so residents can be seen. An interview with the DNS on [DATE] at 11:06 AM identified she in coordination with SW #1 and Assistant Director of Nursing Services oversaw community provider services. Once identified, a request was sent to the community provider who would place the resident on a list to be seen at the next scheduled visit. Any clinical information and physician's orders were to be obtained and sent to the provider prior to the visit. This information was communicated to her through email fax and phone calls from the provider. The DNS identified any recommendations should be reviewed by the APRN and nursing staff should be following up on the status of the recommendations. The DNS further indicated although she received correspondence from the community provider, she was unaware there were any concerns related to residents not being seen, recommendations not being followed, and was unable to explain how the systemic issue occurred. An interview with the Administrator on [DATE] at 10:44 AM identified she would expect that if a resident required specialty services, physician's orders are obtained, residents seen timely, recommendations followed, and the facility would follow up on any resident not seen. A review of the facility policy for Consultation for Outside Medical Appointments (no date) directed to identify the need for an outside medical consultation, schedule an appointment with the appropriate provider, prepare any necessary documents and history for the appointment, document details in the medical record and update the medical record with any new information or recommendations from the consultation, review any instructions from the outside provider, revise the care plan as necessary or follow up appointments and to communicate any outcomes to the resident, responsible party and relevant staff. 48792 48880 (continued on next page)

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49100

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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** 46046 Based on review of the clinical record, review of facility policy and staff interviews for 1 of 3 residents (Resident #13) reviewed for Nutrition, the facility failed to ensure re-weights were obtained when the resident was noted with a 5-pound discrepancy in accordance to facility policy. The findings include: Resident #13 was admitted on [DATE]. The resident's diagnosis included dysphagia. A review of the weights documented in the Weights and Vitals Summary indicated the following: On 1/29/2024 at 3:02 PM Resident #13 was weighed via Hoyer lift on admission and weighed 116.6 pounds. On 2/5/2024 at 11:56 AM Resident #13 weighed 137.0 pounds standing, (a 20.4-pound weight gain in 7 days). On 2/8/2024 at 12:22 PM Resident #13 weighed 142.0 pounds standing, (a 5-pound weight gain in 3 days). The dietician note dated 2/8/2024 at 12:26 PM indicated in part the admission weight of 116.6 was inaccurate as the hospital discharge weight was 126 pounds. A review of weights documented in the Weights and Vitals Summary indicated the following: On 2/11/2024 at 2:48 PM Resident #13 weighed 140.0 pounds standing (a 2-pound weight loss in 3 days). On 2/25/2024 at 2:25 PM Resident #13 weighed 147.0 pounds standing, (a 7-pound weight gain) The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 as moderately cognitively impaired, weighed 147 pounds, had a 5% weight gain in 30 days or 10% gain in the last 6 months and noted the resident was on a mechanically altered diet. A weight documented in the Weighs and Vital Summary dated 3/5/2024 at 8:35 PM noted the resident weighed 148.9 pounds. Resident #13 was discharged on [DATE] and admitted back to the facility on [DATE]. The clinical record identified on 6/19/2024, Resident #13 weighed 136 pounds. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #13 weighed 136 pounds and had a 5 percent loss in the last month or loss of 10% in 6 months and indicated the resident was on a mechanically altered diet. On 7/2/2024 Resident #13 weighed 128 pounds (an 8-pound weight loss in 12 days). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A dietician note dated 7/5/2024 at 11:12 AM indicated Resident #13's weight was down 8 pounds in a month (5.9%) a significant loss and recommended large food portions. On 8/6/2024 at 7:09 PM Resident #13 weighed 134.9 pounds (a 5.9-pound weight gain in 32 days). On 8/8/2024 a dietician note indicated Resident #13 had a significant weight gain 6.9 pounds (5.4 percent) in a month and to continue diet as ordered. On 9/2/2024 at 9:44 PM Resident #13 weighed 145 pounds (a 10.1-pound weight gain in 31 days). A dietician note dated 9/5/2024 at 2:42 PM indicated Resident #13 gained 10.1 pounds in a month and to continue diet as ordered. On 10/2/2024 at 2:43 PM Resident #13 weighed 147.4 pounds (a 2.4-pound weight gain in 30 days). On 10/3/2024 at 2:16 PM Resident #13's weight was stable. On 11/06/2024 at 12:01 PM Resident #13 weighed 156.2 pounds (an 8.8-pound weight gain in 30 days). A dietician note dated 11/7/2024 12:33 PM identified Resident #13 gained 8.8 pounds in a month with an indication this was a beneficial gain and to continue with the diet as ordered. On 12/8/2024 at 12:52 PM Resident #13 weighed 158.3 pounds (a 2.1-pound weight gain in 28 days). An interview with the Dietician on 12/9/2024 at 10:27 AM indicated when there is a discrepancy in weights a request for a reweight would be made. However, the dietician could not recall if and when s/he asked for a re-weight and indicated the facility policy for weight monitoring directs to obtain a reweight if there is a 5 pound loss or gain from the last weight. The dietician also indicated she/he was not concerned about Resident #13's weight discrepancies as Resident #13 eats very well and the weight gain was a true weight gain. On 12/09/24 at 10:40 AM an interview and clinical record review with charge nurse Licensed Practical Nurse (LPN #4) indicated re-weights are obtained if there is a large gain or loss at which time staff would inform the dietician. LPN #4 further indicated for Resident #13 the dietician would decide if a re-weight was needed. LPN #4 further indicated weights are obtained on a work sheet then placed into the electronic system and paper sheets are not kept. On 12/09/24 at 10:48 AM an interview and record review with the ADNS identified reweight should have been obtained per facility policy when weights were 5 pound more or less than the previous weight. The facility policy labeled Weight Monitoring notes if there is a 5-pound weight discrepancy (plus or minus) a reweight should be obtained, the charge nurse is to review the resident's weight and compare it to the previous weights to determine if there is a 5% weight change in 30 days or 10% weight change in 6 months.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46046 Based on observations, review of facility policy and staff interviews, the facility failed to ensure Intravenous Therapy (IV) supplies located in the medication storage room and the central supply were stored and labeled appropriately and the facility failed to ensure supplies were not expired. The facility also failed to ensure left over resident supplies were returned to the pharmacy after therapy completion, discharge, or transfer from facility. The findings included: 1. An observation and interview with the Infection Preventionist (IP) RN #11 on [DATE] at 12:00PM identified the following : individually wrapped loose Intravenous (IV) heparin and saline flushes in large boxes on the lower shelf, several clear bags containing IV flush syringes ordered to particular residents on top of the individual flushes in the boxes. Each box had a laminated card one indicating heparin flushes and the other Normal Saline flushes. Additionally, other individual supplies such as central line dressings were scattered behind the boxes. The IP (RN #11) indicated the flushes were extra supplies and some of the residents supplies needed to be returned as the residents had been discharged . 2. Observation and interview on [DATE] at 12:15 PM with the IP, RN #11 in the central supply closet identified the following: IV supplies in one box (central line tubing and caps), no labels indicating house stock or resident, another large box containing proximately 100 single unused heparin flushes two randomly selected with an expiration date of 2021. RN #11 indicated she/he was the person responsible for ensuring dates supplies are checked for expiration. After inquiry, RN #11 indicated the supplies would be immediately checked. 3. Observation and interview on [DATE] at 1:30 PM on the short-term unit medication room with the IP (RN #11) and the charge nurse LPN #3 identified the following : one of the boxes identified earlier was removed along with the resident specific supplies. RN # 11 further indicted some of the supplies were sent back to the pharmacy. The surveyor pointed out a large box on the medication room shelf indicated Normal Saline flushes, but the contents were Heparin flushes. RN #11 told LPN #3 to label flushes correctly. The facility policy labeled Returning Medications to the Pharmacy dated revised [DATE] indicated in part unopened unused non refrigerated injectable medications and solutions should be (returned within 5 days of discontinuation) and unopened packages of infusion supplies can be returned to the pharmacy for credit. A facility policy for drug destruction was requested but not provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations of the kitchen steam table during the noon meal, review of facility policy and staff interviews, the facility failed to ensure dietary staff served food in a sanitary manner and the facility failed to ensure that food items were labeled with a date and dented cans in the dry storage room were removed. The findings included: 1. Observation on 12/4/2024 at 12:50 PM of Dietary Aide (DA) #1 identified DA# 1 using a plate cover for delivery of a meal to a resident room then walked out of the room with the cover. DA #1 covered the next meal with the same cover she/he walked out of the resident's room and place the cover upside down on the top shelf of the steam table in front of Dietary Aide #2 who was plating the food. Dietary Aide #2 then placed his/her bare hand over the edge of the plate cover with fingers inside the cover then moved his/her hand off the cover and proceeded to plate a meal for another resident. Dietary Aide #1 then took the same plate cover turned it right side up, covered the next meal and delivered it to a resident room. When Dietary Aide #1 exited the resident room s/he was holding the inside of the plate cover against his/her clothing and walked back to the steam table. An interview with Dietary Aide #1 and #2 12/4/2024 at 12:55 PM at the time of the observation Dietary Aide #1 indicated she/he did not have enough clean covers for each resident plate and was nervous therefore she/he used the same plate cover held it against his/her clothing. Dietary Aide #2 could not explain why she/he used her/his bare hand and fingers over the edge of the plate cover and indicated she/he was sorry for touching the inside of the plate cover and would tell Dietary Aide #1 not to reuse the plate covers. On 12/4/2024 at 1:00PM an interview with the Dietary Manager who was informed of the food delivery concerns identified she/he just received a call from the Dietary Aide about the breach in service and indicated the dietary aide should have used a different cover . An interview on 12/06/24 at 12:18 PM with the Dietary Manager identified the same plate cover should not be reused when there is break in dietary practice because the facility has enough plate covers for all the residents. The Dietary Manager also indicated the process for using the plate covers is to take one out of the steam table cover for the plate deliver to the room then come out the room with the plate cover and place it on the bottom shelf of the steam table; they are not to be reused. 2. During a tour of the Dietary Department on 12/2/24 at 9:59 AM during the initial walk through the kitchen with the Dietary Manager identified the following: a. Observation of the Walk in Refrigerator identified 2 packs of [NAME] Choice Hamburger Buns, 1 pack of [NAME] Choice Hot Dog rolls, 2 packs of [NAME] Choice Bread, 1 pack of [NAME] Rolls, and 1 pack of [NAME] English muffins opened and without the benefit of a date of opened. Interview with the Dietary Manager on 12/2/2/24 at 10:08 AM identified the above food items should be dated once opened. She indicated all kitchen staff are responsible for dating open items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Stock Rotation Policy notes in part When food items are removed from original case, date individual contents. All items need to be individually dated when removed from original containers. b. Observation of the dry storage room identified 13 cans of 10 oz Nemco Diced Peaches were dented. Interview with the Dietary Manager on 12/2/24 at 10:25 AM identified all Dented items should be removed from the storeroom and returned to the vendor. The Dietary Manger further indicated she was responsible for ensuring dented cans are not placed in the storeroom but was unable to explain why dented cans were not removed. Facility's Damaged Food Container Policy notes in part cans that contain a deep, angular dent with acute crimping of body wall or end seam, (should be) removed from the storeroom and return to vendor. 49100

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, clinical record reviews, facility documentation, facility policy and interviews for of 2 of 4 sampled residents (Resident #28 and Resident #32) reviewed for urinary catheter/urinary tract infection, the facility failed to ensure infection control standards were implemented in the management of a urinary catheter device and for 2 of 2 resident reviewed for Infection Control (Resident # 71 and # 153), the facility failed to post signage to alert staff of the need for Personal Protective Equipment and ensure supplies were readily available for residents with infectious and consistently track/monitor residents with infections and for 1 of 3 residents (Resident # 2) reviewed for pressure ulcer, the facility failed to follow appropriate infection control practices. The findings included: 1. Resident #28's diagnoses included obstructive and reflux uropathy and other disorders of the prostate. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 as moderately cognitively impaired and required (1) to (2) assist with Activities of Daily Living (ADL). The Resident Care Plan (RCP) dated 11/12/24 identified Resident #28 had an indwelling urinary device in place. Interventions directed provide catheter care as ordered, change drainage bag as ordered and provide privacy cover for drainage bag. The physician's orders dated 11/13/24 directed catheter care every shift and apply leg bag when out of bed. An observation with the Director of Nursing Services (DNS) on 12/02/24 at 10:58 AM identified Resident #28 in a johnny coat sitting in a wheelchair next to her/his bed with urine collection tube extending out from between h/her legs to a urine collection device full of tea colored urine in a basin on the floor beside h/her and without the benefit of a privacy cover. An interview with the DNS on 12/02/24 at 10:58 AM identified the urinary collection device should be hanging on the side of the wheelchair and she/he was unsure why the bag was placed in a basin on the floor. An interview with Nurse Aide, NA #10 on 12/04/24 at 2:45 PM identified he was assigned to Resident #28 on 12/2/24 during the 7:00 AM to 3:00 PM shift and he routinely left the urine collection device in basin directly on the floor next to h/her. 2. Resident #32 's diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms, Methicillin Resistant Staphylococcus Aureus Infection and Chronic Obstructive Pulmonary disease (COPD). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #32 as cognitively intact and required maximal assistance for toileting hygiene, bed mobility and personal hygiene. A physician's order dated 1/18/24 directed to Change Foley Catheter bag ever week and ass needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 9/23/24 identified Foley. Interventions included changing the catheter and bag as needed. Observation on 12/03/24 at 9:50 AM of Resident # 32's Foley bag on the floor uncovered. Observation on 12/03/24 at 11:30 of Resident # 32 'Foley bag on the floor and uncovered. Interview with Registered Nurse (RN #5) on 12/03/24 at 11:35 AM indicated she was unsure of what the privacy bag was, therefore, she informed Resident #32's nurse to obtain a privacy bag. RN #5 noticed it was not done and stated nurses are responsible for ensuring the Foley is covered and not on the floor. A review of the facility policy for Catheter Care (dated 9/30/22) directed that a urinary collection bag should never be paced on the floor and should be hanging lower than the resident's bladder. 3. Resident #71's diagnosis included urinary tract infection and Extended Spectrum Beta lactamase (ESBL) Resistance. A physician's order dated 11/1/2024 directed to provide contact precautions due to ESBL in urine. A physician's order dated 11/1/2024 directed to provide Meropenem Intravenous reconstituted solution providing 1 gram intravenously every 8 hours for 9 days to treat bacteremia (end date of 11/10/2024). The baseline care plan dated 11/3/2024 indicated Resident #71 had urinary tract infection with ESBL and was on enhanced barrier and contact precautions. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #71 had severe cognitive impairment and received Intravenous (IV) antibiotics. The care plan dated 11/6/2024 indicated to use enhanced barrier precautions for residents with medical devices or those colonized or infected with a Multi Resistant Organism (MDRO). The care plan further indicated Resident #71 had a Peripherally Inserted Central Catheter (PICC) with interventions which included placing an EBP sign outside the room, instruction on using EBP, and for Resident #71 to remain on EBP during his/her stay in the facility. A nursing progress note dated 11/29/2024 at 3:48 PM indicated preliminary urine culture results were gram negative rods greater than 100,000 colony count with the antibiotic sensitivities still pending. An observation on 12/2/2024 at 10:50 AM identified Resident #71 in bed, a sign outside the room on the right side of the door indicating EBP and a small bright green dot next to Resident #71's name plate. No protective equipment cart was noted outside of the room. Upon entering the open door to the room another sign indicating Contact Precautions was posted in the middle of the door but no indication of which resident in the shared room the signage applied to. Meanwhile a nurse's aide entered the room to assist the resident's roommate. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview with LPN #4 on 12/2/2024 at 10:54 AM identified residents requiring EBP don't have a PPE cart outside each person's room as a cart is located on the wing to obtain supplies needed. LPN #4 indicated she/he not knowing which sign applied which resident but knew Resident #71 was on EBP and indicated she/he would ask the Assistant Director of Nursing (ADNS) for clarification. An observation and interview with the ADNS on 12/2/2024 at 11:00 AM indicated Resident #71 had been treated for an infection and no longer needed contact precautions and took the sign down. A provider progress note dated 12/2/2024 at 3:15PM indicated in part Resident #71 had a urinalysis the week prior after reported behavioral changes and the results exceeded 100,000 per ml colony count of ESBL. The progress note further indicated though Resident #71 had completed IV antibiotic therapy on November 10,2024 the plan would be to treated with Meropenem 1 gram IV every 8 hours for 14 days. An observation and interview on 12/3/2024 with the Infection Preventionist (IP) identified no contact precautions sign or Personal Protective Equipment (PPE) cart outside Resident #71's room. After surveyor observation IP indicated proper signage, and a cart would be initiated immediately. 4. Resident 153's diagnosis included urinary retention and wounds involving less than 10 percent of the body surface. Resident #153 was admitted on [DATE]. A nurse's note dated 11/21/2024 at 3:13 PM indicated Resident #153 refused to be assessed during wound rounds indicating his/her preference was to go to the wound clinic for wound care. A nurse's note dated 11/25/2024 at 1:37 PM as a late entry indicated Resident #153's wounds and wound measurements noted 7 wounds 6 of which had a depth of 0.1 Centimeter (CM) and 2 of the wounds having 4 and 10 sutures in place. A practitioner progress note dated 11/27/2024 indicated on 11/25/2024 Resident # 153 was experiencing urinary retention requiring a straight catheterization to empty the bladder and the next day (11/26/2024) an indwelling catheter was placed due to continued urinary retention. A practitioner note dated 11/30/2024 at 2:02 PM indicated in part to continue wound care of the second degree burn on the chest wall and to monitor healing of multiple burn sites and graft areas. Interview and facility document review on 12/3/2024 at 1:40 PM with the Infection Preventionist (IP) RN #11 indicated Resident #153 was on the Enhanced barrier precautions list due to having an indwelling urinary catheter. RN #11 indicated the Foley was placed after admission secondary to many wounds. The further indicated when Resident #153 was admitted with, s/he should have had enhanced precautions in place from admission (14 days ago). Observation of Resident #153's room identified no signage posted indicating Resident #153 required enhanced precautions at this time. RN #11 indicated Resident # 153's signage would be posted immediately. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy labeled Enhanced Barrier Precautions (EBP) indicated in part EBP provides a targeted gown and glove use during high contact resident activities. The procedure directed by the RN or designee competing the admission assessment would review the hospital transfer/discharge documentation to determine the presence of a Multi Drug Resistant Organism (MDRO). The facility will implement enhanced barrier precautions to include any resident with an indwelling medical device such as a central line or urinary catheter or chronic wounds. The policy further indicated appropriate signage for EBP would be visible and the facility would implement appropriate precautions when residents are experiencing an active infection. The facility policy labeled Contact precautions indicated in part the purpose is to ensure appropriate precautions are put in place to prevent the spread of infection from direct and indirect transmission from those residents who have a known or suspected to be infected with microorganisms which can be transmitted by direct or indirect contact. The policy further indicates personal protective equipment (PPE); gloves when entering room, touching the resident and patient's immediate environment or belongings and gowns are to be worn in part if substantial contact with the resident's environmental surfaces or items, or if the resident is incontinent or has wound drainage not contained with a dressing. 5.Resident #2 's diagnoses included Pressure Ulcer (PU) stage 3, local infection of the skin, and diabetes mellitus type 2. A physician's order dated 5/28/24 directed Resident #2 to be placed on enhanced barrier precautions. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 as severely cognitively impaired and was dependent for transfers, eating, and required maximum assistance for toileting. The Resident Care Plan dated 10/17/24 identified right buttock stage 3 PU. Interventions included to follow facility protocol/formulary for treatment of pressure ulcers. Observation of Resident # 2's wound care on 12/5/24 at 10:30 AM with the APRN (Wound Consultant and wound/IP nurse.) identified the residents wound was cleansed and a Calcium Alginate dressing was applied. The wound measured 1.5 CM x 7 CM which is smaller than the last measurements. Further observation of nurses conducting the wound treatment identified they did not gown for the procedure for a resident is on Enhanced Barrier Precautions. Interview with Wound APRN and IP on 12/5/24 at 10:45 AM identified the resident was on EBP and required gloving and gowning. APRN #1 and IP identified they did not follow facility protocol by not gowning during wound treatment. Both APRN and IP stated they usually gown. Review of the Enhanced Barrier Precautions policy dated 5/5/24 directed, in part, staff will perform hand hygiene and don PPE before providing high-contact care to the resident 46046 48792 49100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Shelton Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observation, review of facility documents and staff interviews, the facility failed to ensure the call bell system on the rehabilitation wing was functioning properly and relayed calls directly to the centralized nursing station. The findings include: A concern was received by the state agency on 1/5/2024. The concern indicated that when a call bell was pushed it would light up above the resident's door but would not ring at the nurse's station. The concern also indicated the person who had spoken to staff about the call bell issues without a resolution. On 12/4/24 at 10:30 AM the call bell system was tested with NA#15. The call light at the head of the bed for room [ROOM NUMBER] and room [ROOM NUMBER] were tested . On both observation with NA#15 the lights outside the rooms lit up, and there was no sound at the nurse's station. An observation with NA#15 identified that the call bell system at the nurse's station did not display the room number that was calling; instead, the call bell system displayed the following error message: interface missing units 154 [sat] 01 29 21/09/24. An interview with NA#15 identified that NA#15 did not know what the error message displayed was and indicated the call bells were working the day before and she/he was not aware of any call bell issues or repairs. NA #15 indicated if the call bell did not sound at the nurse's station, she/he would be able to tell if a resident was calling because she/he would be able to see the light outside the room. On 12/4/24 at 10:37 AM an interview with the Director of Maintenance identified that he was not sure how long the call bell system was displaying the error but indicated it was related to a part that was malfunctioning and needed to be replaced. The Director of Maintenance also indicated when the malfunction of the call bell is intermittent and when error message occurs the system needs to be rebooted in a panel located in the Staff Development office. The Director of Maintenance proceeded to reboot the call bell system, and the call bell system resumed functioning with an audible sound. The Director of Maintenance further indicated that around December of 2023 and January 2024 the call bell system malfunctioned, and an electrician repaired it. A review of facility records identified that a work order was signed with a vendor for repair of the call bell system on 9/30/2024. On 10/4/2024 the vendor diagnosed the issue and, according to facility documentation, returned the majority of the system back to full functionality except for an office, lounge and therapy gym. Facility records also noted to finish the repairs a part needed to be ordered. Additionally, the vendor recommended ordering spare parts for any future repairs. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 10/28/2024 the corporate office of the facility followed up with the vendor regarding updates; the vendor responded on 10/31/2024 indicating they were waiting for confirmation of parts shipment. On 11/25/2024 the facility again contacted the vendor for updates, the facility documentation did not indicate a vendor response. On 12/4/2024 after the surveyor inquiry, the facility contacted the vendor again. On 12/4/2024 the vendor indicated they would attempt to expedite shipment of the parts needed for the repair of the call bell system as the additional spare parts were requested by the facility delaying the shipment. The vendor estimated the repair would be completed by 12/20/2024 (2 months and 20 days after the proposal for service was approved by the facility.) Although requested, the facility was unable to provide documentation regarding the repairs done by a corporate regional electrician to the call bell system in the rehabilitation wing around December 2023 and January 2024. On 12/5/2024 at 1:00 PM an interview and review of the 12/4/2024 facility documentation with the Administrator identified she been aware of the need for additional spare parts ordered for potential future repairs were delaying shipment of the spare parts needed for the call bell repair. The Administrator further indicated she would ensure that the required parts are sent, and the call bell repaired. The facility policy for call bells notes any non-functional call bell should be reported to the maintenance in a timely manner. If there is an extended period of downtime anticipated, the residents should be provided with an alternative method of requesting assistance.