STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 3 residents (Residents #257, 258, and 260) reviewed for advance directives, the facility failed to review and obtain, upon the residents' admission, the advance directives and code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops). The findings include: 1. Resident #257 was admitted to the facility on [DATE] with diagnoses that included alcoholic cirrhosis of the liver with ascites, muscle weakness, and difficulty walking. Review of the clinical record identified that Resident #257 was responsible for self and the admission MDS had not yet been completed. The baseline care plan dated [DATE] identified Resident #257 needed assistance with activities of daily living (ADLs). Interventions included advance directives per the physician's order. A Medical Interventions Consent form dated [DATE] and signed only by the physician, was blank and did not identify Resident #260's choice(s) for the administration of life support systems in the event of a medical emergency. The form included the following options for the residents to choose from. a. Cardiopulmonary Resuscitation (CPR). b. Do not resuscitate/Do not intubate (DNR/DNI). c. Artificial means of nutrition. d. Intravenous (IV) fluids. d. hospitalization . e. Other specific requests. The physician's orders dated [DATE] through [DATE] failed to identify an order for Resident #257's code status (code status directs the medical team to administer or withhold life support systems in the event of a cardiac or respiratory arrest). (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medical Interventions Consent form, signed by the resident, and dated [DATE] identified Resident #257's choices regarding the administration of life support systems were CPR, artificial means of nutrition, IV fluids, and hospitalization . An undated physician's order directed Resident #257's code status as a full code (full code directs the medical team to take all possible measures to save the residents' life in the event of a medical emergency). Interview and review of the clinical record with RN #1 on [DATE] at 1:18 PM identified that an order was written on [DATE] directing Resident #257 to be a full code and the Medical Interventions Consent form was completed and signed by Resident #257 on [DATE] (5 days after admission). RN #1 further identified that Resident #257 was responsible for self and that she would expect that the Medical Interventions Consent form and a physician's order to be completed on admission. Interview and review of the clinical record with the DNS on [DATE] at 1:51 PM identified that there should not have been a delay in completing Resident #257's Medical Interventions Consent form and obtaining a physician's code status order. The DNS further identified that it is the responsibility of the nursing supervisor on the floor to review the Medical Interventions Consent form with the resident and then obtain the appropriate order, at the time of admission or within 24 hours. 2. Resident #258 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis, chronic obstructive pulmonary disease, and a non-ST elevation myocardial infarction. Review of the clinical record identified that Resident #258 was responsible for self and the admission MDS had not yet been completed. The baseline care plan dated [DATE] identified Resident #258 required assistance with activities of daily living (ADLs). Interventions included Advance Directives per the physician's order. A Medical Interventions Consent form in the record was blank and did not identify Resident #258's choice(s) for the administration of life support systems in the event of a medical emergency. The form included the following options for the residents to choose from. a. Cardiopulmonary Resuscitation (CPR). b. Do not resuscitate/Do not intubate (DNR/DNI). c. Artificial means of nutrition. d. Intravenous (IV) fluids. d. hospitalization . e. Other specific requests. The physician's orders dated [DATE] through [DATE] failed to identify an order for Resident #258's code status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medical Interventions Consent form signed and dated [DATE] identified Resident #258's choices regarding the administration of life support systems were CPR, artificial means of nutrition, IV fluids, and hospitalization . A Physician's order dated [DATE] directed Resident #258 as a full code. Interview and review of the clinical record with RN #1 on [DATE] at 1:18 PM identified that an order was written on [DATE] directing Resident #258 to be a full code and the Medical Interventions Consent form was completed and signed by Resident #258 on [DATE] (5 days after admission). RN #1 further identified that Resident #258 was responsible for self and that she would expect that the Medical Interventions Consent form and a physician's order to be completed and in the clinical record on admission. Interview and clinical record review with the DNS on [DATE] at 1:51 PM identified that there should not have been a delay in completing Resident #258's Medical Interventions Consent form and obtaining a physician's code status order. The DNS further identified that it is the responsibility of the nursing supervisor on the floor to review the Medical Interventions Consent form with the resident and then obtain the appropriate order, at the time of admission or within 24 hours. 3. Resident #260 was admitted to the facility on [DATE] with diagnoses that included syncope, neoplasm of the brain, and first- and second-degree atrioventricular blocks. Review of the clinical record identified that Resident #260 was responsible for self and the admission MDS had not yet been completed. The baseline care plan dated [DATE] identified Resident #260 needed assistance with activities of daily living (ADLs). Interventions included Advance Directives per the physician's order. A Medical Interventions Consent form in the record was blank and did not identify Resident #260's choice(s) for the administration of life support systems in the event of a medical emergency. The form included the following options for the residents to choose from. a. Cardiopulmonary Resuscitation (CPR). b. Do not resuscitate/Do not intubate (DNR/DNI). c. Artificial means of nutrition. d. Intravenous (IV) fluids. d. hospitalization . e. Other specific requests. The physician's orders dated [DATE] through [DATE] failed to identify an order for Resident #260's code status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A signed Medical Interventions Consent form dated [DATE] identified Resident #260's choice regarding the administration of life support systems was DNR/DNI. A physician's order dated [DATE] directed Resident #260's code status as a DNR/DNI, RN may pronounce death. Interview with RN #1 on [DATE] at 1:18 PM identified that she had received a telephone order from the APRN directing Resident #260's code status to be a DNR/DNI, and she had Resident #260 complete and sign the Medical Interventions Consent form, earlier that day (4 days after admission). RN #1 further identified that Resident #260 was responsible for self and that she would expect that the Medical Interventions Consent form and a physician's order to be completed and in the clinical record on admission and if the resident can't sign for him/herself then they remain a full code (CPR) until specified otherwise by the responsible party. Interview and review of the clinical record with the DNS on [DATE] at 1:51 PM identified that there should not have been a delay in completing Resident #260's Medical Interventions Consent form and obtaining a physician's code status order. The DNS further identified that it is the responsibility of the nursing supervisor on the floor to review the Medical Interventions Consent form with the resident and then obtain the appropriate order, at the time of admission or within 24 hours. The DNS indicated that she would conduct re-education pertaining to completing the Medical Interventions Consent form and obtaining a code status order in a timely manner, and audits of advance directive documentation would also be completed. The facility's Advance Directives policy directs that upon admission to the facility, the advance directives will be reviewed with the resident and/or the resident's substitute decision maker by the licensed nursing staff or the attending physician, if a decision is made regarding advance directives, the advance directive consent form will be signed and dated by the resident or substitute decision maker, the physician, and the person who explained the advance directives. The policy further directs that the advance directive consent form will be kept in the resident's medical record and a physician's order will be obtained regarding advance directives. If no decision is made related to advance directives the resident will remain a full code until a decision is made by the resident or substitute decision maker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #26) reviewed for accidents, the facility failed to ensure that a physician ordered medication was administered by a licensed nurse, was not left at the bedside, and was not expired and for 2 of 3 residents (Resident #31 and Resident 308) reviewed for medication administration observation, the facility failed to utilize resident identifiers to ensure the resident received the correct medication prior to administering the medication. The findings include: 1. Resident #26 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, heart attack, and stroke. Review of the clinical record identified that Resident #26 had a conservator of person upon admission to the facility on [DATE]. A physician's order dated [DATE] identified Resident #26 required monitoring every shift for behaviors that included refusing care. A physician's order dated [DATE] directed to administer saline nasal spray, one spray to each nostril 3 times daily for dry nose and chronic nose bleeds. The care plan dated [DATE] identified Resident #26 had a history of being resistive to care and treatments. Interventions included to discuss implications of not complying with the therapeutic regime. The quarterly MDS dated [DATE] identified Resident #26 had moderately impaired cognition, was dependent on staff with dressing, bathing, and toileting. The MDS also identified that Resident #26 had exhibited behaviors that included rejection of care 4 - 6 days but less than daily. Review of the clinical record admission through [DATE] failed to identify any evaluations, care plans or education provided related to Resident #26 self-administering medications. Observation on [DATE] at 9:05AM identified a 1.5 fluid ounce bottle of Deep Sea Premium Saline Nasal Moisturizing Spray on the resident's bedside table. The nasal spray had Resident #26's last name handwritten along the top portion of the bottle with the date [DATE]. Interview with Resident #26 at that time identified the nasal spray was provided by the facility and left with the resident at his/her bedside. Resident #26 identified that he/she used the nasal spray three times a day for dry nose to help prevent nose bleeds. Observation and interview with Resident #26 on [DATE] at 1:45 PM identified the nurse assigned to him/her removed the saline bottle his/her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on [DATE] at 1:50 PM identified she was the nurse assigned to Resident #26 and had removed the saline nasal spray and discarded it. LPN #1 identified she was not sure why the nasal spray was in Resident #26's room as it was usually kept locked in the medication cart. LPN #1 identified she discarded the nasal spray because it was expired based on the date of [DATE] written on the bottle. LPN #1 identified that she threw the expired nasal spray away, opened a new bottle for Resident #26 and that the new bottle was locked in the medication cart. LPN #1 identified that medications at the facility were good for 28 days from the open date, which was written on the bottle. Interview with RN #4 (Corporate Clinical Nurse) on [DATE] at 1:55 PM identified that she was unsure why the nasal spray was at Resident #26's bedside if Resident #26 had not been evaluated for self-administration of medication and that the medication must be in a locked location if the resident was self-administering the medication. RN #4 further identified that multi dose medications for residents were labeled with an open date and the use by date was 28 days from that date. Subsequent to surveyor inquiry, RN #4 completed an evaluation for self-administration of medication for Resident #26 on [DATE] at 2:14 PM and identified Resident #26 was able to self-administer medications. The evaluation identified that Resident #26 was unable to identify any side effects of the medication. Interview with the DNS on [DATE] at 9:40 AM identified that dates written on the medication bottles varied depending on the medication. The DNS also identified that any medication provided by the facility for residents to self-administer should not be left at the bedside of the resident due to safety concerns as any medication left out in the open could be accessed by another resident. The DNS further identified that any resident who self-administered medications should have an evaluation to ensure that the resident was clinically appropriate and capable to manage medications at the bedside and to self-administer medication, and that would include providing education to the resident, having the resident provide a return demonstration of self-administering the medication, and that information would be documented in the clinical record. The DNS identified that Resident #26 had cognitive issues, a history of refusing care, medications, and noncompliance with his/her plan of care. The DNS identified she did not feel Resident #26 would be clinically appropriate to self-administer or keep medications within his/her room and she was not aware RN #4 had completed any evaluations for Resident #26. The facility policy on self-administration of medication directed that medications at the resident's bedside, including prescription and over the counter medications, should be kept in a manner that should prevent access by other residents. The policy further directed to ensure safe and appropriate self-administration, the facility would ensure the resident was able understand possible medication side effects, notify the facility staff of side effects, correctly administer the medication, and store the medication in a locked compartment. The policy also directed that residents should be regularly observed to determine the resident's cognitive and functional skills allowed for safe and appropriate continuation of self-administration, and that any issues related to observations of the resident missing medication doses, refusing medications should be reported to the DNS or supervisor immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on storage and expiration dating directed that medications should be labeled when a medication had a shortened expiration date once opened, and that facility staff may record the calculated expiration date, based on the date opened, on the medication container. The policy also directed that all expired/outdated or deteriorated medications should be destroyed within pharmacy guidelines. The policy also directed that the facility should not provide/administer bedside medications without a physician/prescriber order and approval from the interdisciplinary care team and facility administration. The policy further identified that bedside medications should be stored within a locked compartment within the resident's room. 2a. Resident #308 was admitted to the facility on [DATE] with diagnoses that included cirrhosis of liver, muscle weakness, and difficulty in walking. A physician's order dated [DATE] directed to check the identification band prior to medication administration. Observation on [DATE] at 8:04 AM during medication administration identified LPN #1 carried prepared medications to Resident #308's bedside and administered the medications. LPN #1 did not verify the identification band prior to administering the medication. Interview with LPN #1 on [DATE] at 8:05 AM identified she did not use a resident identifier when she administered the medications because she remembered Resident #308 from the day prior. 2b. Resident #31 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, congestive heart failure and acute kidney failure A physician's order dated [DATE] directed to check the identification band prior to medication administration. Observation on [DATE] at 8:50 AM during medication administration identified LPN #2 indicated she does not usually pass medications on this unit. LPN #2 was observed to prepare medications for Resident #31. Upon arrival to Resident #31's bedside, LPN #2 indicated she knew the resident and proceeded to administer the medications. Resident #31 was not wearing an identification band. Interview with LPN #2 on [DATE] at 9:25 AM indicated she would have used resident identifiers to identify Resident #31 if she did not know the resident. LPN #2 indicated she would use the name plate outside of the resident room or the electronic medical record photo for identifiers for residents she does not know. Interview with the DNS on [DATE] at 12:24 PM identified it is facility policy that resident identifiers are used prior to medication administration. Review of the Medication Administration policy directs the policy purpose is to ensure safe, accurate, and effective administration of medications to residents promoting optimal health outcomes while minimizing medication errors. The policy further directs to confirm the residents identity using at least two identifiers (e.g. , name and date of birth) before administering medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 4 residents (Resident #38 and 46) reviewed for accidents, the facility failed to ensure neurological assessments and post fall assessments were completed per policy, and for 1 resident (Resident #259) reviewed for behaviors, the facility failed to administer an anxiolytic medication according to the physician's order, and for 1 of 1 residents (Resident #158) reviewed for indwelling catheters, the facility failed to obtain a physician's order for the catheter. The findings include: 1. Resident #38 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, left femur fracture, hypotension, and muscle weakness. The admission MDS dated [DATE] identified Resident #38 had severely impaired cognition, was dependent for chair/bed-to-chair transfers, and had sustained a fracture related to a fall, in the last 6 months. The care plan dated 8/1/24 identified Resident #38 was at risk for falls due to multiple risk factors. Interventions included maintaining commonly used articles within easy reach, provision of a clutter free environment, and analyzing previous falls to determine whether a pattern or trend could be addressed. a. The nurse's note dated 8/2/24 at 5:40 PM identified that Resident #38 was found on the floor in the hallway, outside of the Serenity room, lying next to his/her wheelchair. The note further identified that Resident #38 had poor safety awareness, multiple falls, was assisted by staff up to the wheelchair, and reported discomfort in the left hip area without external rotation or deformity observed. A reportable event form dated 8/2/24 failed to neurological checks was completed, following the unwitnessed fall. The nurse's notes dated 8/2/24 through 8/4/24 failed to identify neurological checks had been completed. b. The nurse's note dated 8/6/24 at 11:09 AM identified Resident #38 had an unwitnessed fall, no changes to mental status observed, and no changes in neurological, respiratory, or GI system status observed. A reportable event form dated 8/6/24 failed to identify neurological checks were completed following the unwitnessed fall. The nurse's notes dated 8/6/24 through 8/8/24 failed to identify neurological checks were completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	Interview and review of the clinical record with the DNS on 8/12/24 at 2:09 PM failed to identify that neurological checks had completed following the unwitnessed falls on 8/2/24 and 8/6/24. The DNS indicated that it is the responsibility of the charge nurse to complete and document neurological checks for 72 hours after an unwitnessed fall, if the resident is unable to accurately communicate if he/she hit their head, per the facility policy. The facility's Falls: Minimizing Risk of Injury policy directs that each time a resident experience a fall, an Accident and Incident (A&I) report will be completed and an interdisciplinary fall assessment to identify the potential causes of the fall. Statements will be obtained from staff members at the time of the fall. A status post A&I assessment and neurological checks will be completed if any resident that experiences an unwitnessed fall and is unable to accurately verbalize if he or she hit their head due to cognitive status or experienced any type of injury. The post A&I assessment and neurological monitoring will be documented for 72 hours. 2. Resident #46 was admitted to the facility on [DATE] with diagnoses that included chronic myeloproliferative disease, chronic obstructive pulmonary disease (COPD) and difficulty walking. The care plan dated 2/13/24 identified Resident #46 was at risk to fall due to multiple risk factors including an unstable health condition. Interventions included to keep the call bell within reach and ensure the environment was free of clutter. The admission MDS dated [DATE] identified Resident #46 had moderately impaired cognition, was always incontinent of bowel and bladder and required maximal assistance from staff with transfers and dressing and was dependent on staff assistance for toileting. The MDS also identified Resident #46 required a wheelchair and had a history of falls within the 30 days prior to admission to the facility. A reportable event form for Resident #46 identified an unwitnessed fall on 2/26/24 at 4:15 AM. The report identified Resident #46 rolled out of bed, which was in the lowest position, and onto the floor, and that Resident #46 reported looking for his/her spouse. Interventions included initiation of neurological checks and mats on Resident #46's floor while in bed. A reportable event form for Resident #46 identified an unwitnessed fall on 3/8/24 at 9:00 PM. The report identified Resident #46 was confused and attempted to retrieve his/her shoes and slipped on the floor. Review of the clinical record failed to identify any neurological assessment documentation following Resident #46's fall on 3/8/24. Further review of the record also identified post accident and incident (A&I) assessment monitoring, which was to be done every shift for 72 hours post fall (beginning 3/8/24 3:00 PM - 11:00 PM and ending 3/11/24 7:00 AM - 3:00 PM), was completed on the following shifts: 3/9/24: 7:00 AM - 3:00 PM and 11:00 PM - 7:00 AM. 3/10/24: 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM. A reportable event form for Resident #46 identified an unwitnessed fall on 4/8/24 at 9:30 AM while in the bathroom. The report further identified Resident #46 was confused and unable to describe how the fall occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	Review of the clinical record identified neurological assessments and post A&I assessments following Resident #46's fall on 4/8/24 were incomplete. A reportable event form for Resident #46 identified an unwitnessed fall on 4/9/24 at 5:15 PM. The report identified Resident #46 reported sliding out of his/her wheelchair while in his/her room which resulted with a skin tear to the left lower leg. Review of the clinical record identified incomplete neurological assessments and post A&I assessment monitoring following Resident #46's fall on 4/9/24. The post A&I assessment monitoring flowsheet with no identifying information related to a resident name or incident date, was included with Resident #46's clinical record and completed on 4/9/24 during the 11:00 PM - 7:00 AM shift and on 4/10/24 during the 7:00 AM - 3:00 PM shift. The clinical record failed to identify any additional documentation related to neurological or post A & I assessments for Resident #46's falls on 4/8/24 and 4/9/24. A reportable event form for Resident #46 identified an unwitnessed fall on 5/1/24 at 1:30 PM. The report identified Resident #46 was seated in his/her wheelchair and was participating in activities with other residents in the Serenity room, a lounge located on the unit. The report identified Resident #46 was then observed on the floor and was unable to articulate how the fall occurred. The clinical record failed to identify any documentation related to neurological or post A & I assessments following the 5/1/24 fall. A reportable event form for Resident #46 identified an unwitnessed fall on 7/1/24 at 2:30 PM. The report identified Resident #46 fell out of the wheelchair while in his/her room and was found on the floor in the fetal position with a bump to the right side of the forehead. The report further identified Resident #46 was unable to articulate how the fall occurred and was sent to the hospital for evaluation and returned on 7/2/24 at approximately 10:00 AM. Review of the clinical record identified neurological assessments and post A&I assessments were incomplete. Review of the clinical record identified post A&I assessments were completed following the 7/1/24 fall once daily on the 7:00 AM - 3:00 PM shift from 7/1/24 - 7/3/24 (should be done every shift for 72 hours post fall). Further, the clinical record failed to identify any additional documentation related to neurological assessments following the 7/1/24 fall. A reportable event form for Resident #46 identified an unwitnessed fall on 7/5/24 at 9:15 AM. The report identified Resident #46 was found on the floor of the Serenity room next to his/her wheelchair and reported he/she did not know what happened. Review of the clinical record identified the neurological assessment flowsheet, which did not include any information related to a resident name or date of incident, located within the 7/5/24 reportable event form for Resident #46 was completed on 7/5/24 9:15 AM, 6:15 PM, and 10:15 PM. On 7/6/24 at 2:15 AM documented resident was sleeping, no neurological assessment. On 7/6/24 during the 11:00 PM - 7:00 AM shift documented resident was sleeping, no neurological assessment and on 7/7/24 during the 11:00 PM - 7:00 AM shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	The clinical record failed to identify any additional documentation related to neurological assessments following the 7/5/24 fall. A reportable event form for Resident #46 identified an unwitnessed fall on 7/28/24 at 3:30 PM. The report identified Resident #46 was found on the floor of the Serenity room alone and reported he/she slid out of his/her wheelchair. Review of the clinical record identified one post A&I assessment completed following the 7/28/24 fall during the 3:00 PM - 11:00 PM shift. The clinical record failed to identify any additional post A&I assessments, or any neurological assessments initiated or completed related to this fall. A reportable event form for Resident #46 identified an unwitnessed fall on 8/5/24 at 1:45 PM. The report identified Resident #46 found on the floor of the Serenity room alone and was unable to identify what happened. The clinical record failed to identify any neurological assessments initiated or completed related to this fall. Interview with the DNS on 8/13/24 at 9:45 AM identified that she was aware of Resident #46's frequent falls. The DNS identified she had only been employed by the facility for approximately 8 weeks and was working to improve fall interventions for all residents. The DNS identified that for any resident who fell , the resident should have a physical assessment by a RN, including vital signs and neurological checks, and that the provider should be notified. The DNS also identified that neurological assessments should be done per facility policy for 72 hours for any unwitnessed falls and that assessments should also be done every shift for 72 hours after any accident or incident. The DNS identified that she was working with staff regarding education to improve investigations regarding falls, that appropriate interventions were added to the resident's care plan, and that assessments were documented in the clinical record per the facility policy. Review of the post A&I assessment flowsheet directed that the assessment was to be completed each shift for 72 hours following an accident or incident and to notify the physician if the assessment revealed new or worsened symptoms, and included assessment areas for skin bruising, range of motion, pain, blood pressure, pulse and respirations. The facility policy on falls identified each time resident experienced a fall, post A&I assessments would be completed and documented on for 72 hours after the fall, and that neurological checks would also be completed for 72 hours after a fall for any resident that experienced an unwitnessed fall and was unable to accurately verbalize a head strike due to cognitive status or experienced any type of head injury. The facility policy on neurological assessments directed that neurological checks were used to assess a resident's neurological status following a head injury or any other situation that might alter the resident neurological status, including a fall when a resident was unable to cognitively verbalize a head injury. The policy further directed that the neurological flow sheet would be instituted by the nurse and would be completed every 15 minutes for the first hour, every hour for 4 hours, every 4 hours for the next 24 hours, and every shift for 48 hours after that. The policy directed that the flowsheet documentation should include the date and time of the assessment, the level of consciousness, the pupillary response, the strength and sensation of the extremities, and vital signs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	47457 3. The inter-agency referral report dated 8/1/24 identified Resident #259 had a past medical history of mental health issues. The report further identified Resident #259's discharge medication and orders included, 1mg Alprazolam (commonly known as Xanax), take 1 tablet by mouth, twice daily, for anxiety. Resident #259 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, anxiety, and major depressive disorder. The nursing admission assessment dated [DATE] identified Resident #259 was able to recall the following: current season, that he/she was in a nursing home, and location or room. The nursing admission assessment further identified that Resident #259 had taken the following medications more than 3 times per week: benzodiazepines, cathartics, narcotics, psychotropics, and sedative/hypnotics. A physician's order dated 8/1/24 directed to administer 1mg of Alprazolam by mouth, twice daily, for anxiety. The nurse's note dated 8/1/24 at 6:21 PM identified Resident #259's orders were reviewed and confirmed by the APRN. The baseline care plan dated 8/8/24 identified Resident #259 was at risk for changes in mood state due to diagnoses of depression and chronic illness. Interventions included to be aware of and report any changes in mood state when a new medication is added. The August 2024 MAR identified Resident #259 missed 4 doses of 1mg of Alprazolam (a benzodiazepine) on the following dates and times. 8/3/24 at 9:00 AM. 8/5/24 at 5:00 PM. 8/6/24 at 9:00 AM. 8/6/24 at 5:00 PM. The nurse's note dated 8/6/24 at 11:15 AM identified that Resident #259 complained of nausea and the nausea was entered into APRN book for evaluation. Further, Resident #259 reported 1 episode of emesis. New orders were received to administer 4mg of Zofran every 6 hours, as needed (prn) for nausea and vomiting. The pharmacy was called and the pharmacy technician identified he will STAT the medication. The nurse's note dated 8/7/24 at 12:42 PM identified prn Zofran and scheduled 1mg Alprazolam were administered with positive effect, no further episodes of anxiety or emesis reported on this shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	Interview with Resident #259 on 8/11/24 at 8:05 AM identified that he/she is supposed to take Xanax and that the facility nurses didn't understand that if a dose was missed, he/she would get sick and throw up. Resident #259 further indicated that a dose was missed shortly after being admitted to the facility; subsequently, he/she reported being sick for 2 days. Interview and review of the clinical record with LPN #1 on 8/12/24 at 7:16 AM identified that she was unable to medicate Resident #259 with 1mg Alprazolam during the morning medication pass on 8/6/24 because the medication was unavailable. LPN #1 indicated that she notified the pharmacy that the medication was unavailable, around 11:15 AM that morning and was told that there was something wrong with the prescription, but they would send the medication. LPN #1 further indicated that Resident #259 had received some of his/her prior doses utilizing the emergency box supply. Interview with Pharmacy Consultant #1 on 8/12/24 at 10:22 AM identified that the pharmacy did not receive an order for the Alprazolam or a signed prescription until 8/6/24, and the medication was delivered to the facility on [DATE], during the evening delivery. Interview and review of the clinical record with the RN Supervisor (RN #2) on 8/12/24 at 10:35 AM identified that she entered the order for Resident #259's Alprazolam on 8/3/24, but she was unsure why the pharmacy would not have received the order. RN #2 was also unsure about why the pharmacy did not receive the signed prescription. Interview and review of the clinical record with the DNS on 8/13/24 at 10:30 AM identified that it is her expectation that medications are administered, per the physician's order. The DNS further identified that the physician was out on 8/5/24 and 8/6/24 and that there was an issue with some of the prescriptions for controlled substances being signed. The DNS indicated that while the issue was promptly fixed and was a rare occurrence, a resident should not have missed multiple doses of a medication. Although attempted, an interview with MD #1 was not obtained. The facility's Medication Administration policy directs all medications shall be administered safely and accurately in accordance with the physician orders, facility protocols, and applicable state and federal regulations. 48249 4. Review of the December 2022 admission assessment revealed resident ID # 158 was admitted with a indwelling catheter. The December 18, 2022 Minimum Data Set Admission Assessment revealed the resident requires extensive assistance for toilet use and personal hygiene and indicated the resident had a catheter, urinary ostomy, or no urine output for the entire 7 days. The Resident Care Card revealed that the resident had a 'foley' catheter (type of indwelling catheter). A 12/17/2022 nursing note documented very poor output from foley and the foley was flushed with some output. Review of the nursing discharge summary revealed the resident required extensive assistance with toilet use and had an indwelling urinary catheter. Further record review failed to reveal evidence of a physician's order for a catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 - Few	Interview with the RN #3 on 8/12/24 at approximately 2:15 PM revealed there should be a diagnosis for urinary catheters and an order for the catheter. S/he indicated resident ID #148 had a foley catheter and there should have been a physician's order for the catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #46) reviewed for accidents, the facility failed to provide the necessary supervision, according to the plan of care, to prevent falls. The findings include: Resident #46 was admitted to the facility on [DATE] with diagnoses that included chronic myeloproliferative disease, chronic obstructive pulmonary disease (COPD) and difficulty walking. The care plan dated 2/13/24 identified Resident #46 was at risk to fall due to multiple risk factors including an unstable health condition. Interventions included to keep the call bell within reach and ensure the environment was free of clutter. The admission MDS dated [DATE] identified Resident #46 had moderately impaired cognition, was always incontinent of bowel and bladder and required maximal assistance from staff with transfers and dressing and was dependent on staff assistance for toileting. The MDS also identified Resident #46 required a wheelchair and had a history of falls within the 30 days prior to admission to the facility. A reportable event form for Resident #46 identified an unwitnessed fall on 2/26/24 at 4:15 AM. The report identified Resident #46 rolled out of bed, which was in the lowest position, and onto the floor, and that Resident #46 reported looking for his/her spouse. Interventions included initiation of neurological checks and mats on Resident #46's floor while in bed. A reportable event form for Resident #46 identified an unwitnessed fall on 3/8/24 at 9:00 PM. The report identified Resident #46 was confused and attempted to retrieve his/her shoes and slipped on the floor. The care plan, updated on 3/21/24 (13 days post fall), included an intervention to keep Resident #46's shoes within reach. A reportable event form for Resident #46 identified an unwitnessed fall on 4/8/24 at 9:30 AM while in the bathroom. The report further identified Resident #46 was confused and unable to describe how the fall occurred. Review of the clinical record identified no new interventions were implemented following this fall. A reportable event form for Resident #46 identified an unwitnessed fall on 4/9/24 at 5:15 PM. The report identified Resident #46 reported sliding out of his/her wheelchair while in his/her room which resulted with a skin tear to the left lower leg. Review of the clinical record identified no new interventions were implemented following this fall. A reportable event form for Resident #46 identified an unwitnessed fall on 5/1/24 at 1:30 PM. The report identified Resident #46 was seated in his/her wheelchair and was participating in activities with other residents in the Serenity room, a lounge located on the unit. The report identified Resident #46 was then observed on the floor and was unable to articulate how the fall occurred. Review of the care plan following the fall identified a new intervention to reinforce the need for Resident #46 to call for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A reportable event form for Resident #46 identified an unwitnessed fall on 5/15/24 at 5:30 PM. The report identified Resident #46 was found lying on his/her left side on the floor of the Serenity room, and that Resident #46 reported he/she slid down the wheelchair and rolled over. Review of the clinical record identified no new interventions were implemented following this fall. A reportable event form for Resident #46 identified an unwitnessed fall on 7/1/24 at 2:30 PM. The report identified Resident #46 fell out of his/her wheelchair while in her room and was found on the floor in the fetal position with a bump to the right side of the forehead. The report further identified Resident #46 was unable to articulate how the fall occurred and was sent to the hospital for evaluation and returned on 7/2/24 at approximately 10:00 AM. A CT scan of the head was negative. Review of the clinical record identified no new interventions were implemented following this fall. A reportable event form for Resident #46 identified an unwitnessed fall on 7/5/24 at 9:15 AM. The report identified Resident #46 was found on the floor of the Serenity room next to his/her wheelchair and reported he/she did not know what happened. Interventions implemented following this fall included not leaving Resident #46 in the Serenity room unattended due to poor safety awareness. A reportable event form for Resident #46 identified an unwitnessed fall on 7/28/24 at 3:30 PM. The report identified Resident #46 was found on the floor of the Serenity room, alone, and reported he/she slid out of his/her wheelchair. Interventions implemented on 7/31/24, 3 days post fall, included evaluating for fatigue and restlessness in the afternoon and assist Resident #46 back to bed by 2:00 PM after personal care. A reportable event form for Resident #46 identified an unwitnessed fall on 8/5/24 at 1:45 PM. The report identified Resident #46 found on the floor of the Serenity room, alone, and was unable to identify what happened. Review of the clinical record failed to identify any new interventions implemented following this fall. Review of the Resident Care Card on 8/11/24 for Resident #46 identified that the care card included a note dated 7/31/24 which identified Do not leave unattended in Serenity room. Observation on 8/11/24 at 8:37 AM of the Serenity room identified the room was located across the hallway from the nursing station, however, the location of the entrance door to the Serenity room did not allow direct visualization of the room from any viewpoint in the nurse's station. Observations identified staff would be required to stand directly at the threshold of the entrance door to visualize the entire room. Observation and interview with Resident #46 on 8/11/24 at 10:15 AM identified Resident #46 was unable to identify any information related to care or falls at the facility. Observation identified Resident #46 was seated in his/her wheelchair and was observed rocking back and forth slightly. During this observation, no staff were present in or near Resident #46's room, which was not visible unless directly positioned across from the room entrance. Multiple observations of Resident #46 were completed during the survey from 8/11/24 - 8/13/24 across all 3 shifts between the hours of 6:00 AM and 3:45 PM. During the observations, Resident #46 was not observed at any time in the Serenity room alone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 8/13/24 at 9:45 AM identified that she was aware of Resident #46's frequent falls. The DNS identified she had only been employed by the facility for approximately 8 weeks and was working to improve fall interventions for all residents. The DNS identified that she was working with staff regarding education to improve investigations regarding falls, and that appropriate interventions were added to the resident's care plan. The DNS also identified that nursing staff at the facility had been instructed multiple times that Resident #46 was not to be left in the Serenity room without a staff member present. The facility policy on falls directed that the purpose of the policy included minimizing the resident's risk of injury when a fall occurred and to develop an interdisciplinary care plan with fall/injury prevention strategies. The policy further directed residents who experience a fall would be evaluated following the occurrence to identify the position causes of the fall and that an individualized care plan would be developed and updated as needed to identify interventions to prevent falls and minimize injuries. The policy also directed that each time a resident experienced a fall, the care plan would be revised with any interim interventions to minimize risk of injury. 47457

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 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** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #38) reviewed for nutrition, the facility failed to ensure daily weights were completed per the physician's order. The findings include: Resident #38 was admitted to the facility on [DATE] with diagnoses that included acute chronic systolic (congestive) heart failure, Alzheimer's Disease, and anorexia. The admission MDS dated [DATE] identified Resident #38 had severely impaired cognition, had a mechanically altered and therapeutic diet and had no/unknown weight loss or gain in the last 1 or 6 months. The care plan dated 8/1/24 identified Resident #38 was at risk for cardiac issue (heart attack, chest pain, stroke) related to cardiovascular disease: congestive heart failure (CHF). Interventions included obtaining weights as ordered/per policy. The care plan further identified that Resident #38 had the potential for a nutritional decline related to multiple medical problems, need for a therapeutic diet, need or altered consistency diet, recent hospitalization , and recent surgery. Interventions included encouragement to eat meals independently and to assist as needed, provide diet as ordered, and monitor weights as ordered. A physician's order dated 7/25/24 directed to weigh once daily, in the AM. Call the physician for gain of 3 pounds or more in 24 hours or 5 pounds in one week, for CHF. Although the physician ordered daily weights on 7/25/24, review of the weight and vitals summary dated 7/25/24 through 8/12/24 identified weights were not obtained on 7/25, 7/26, 7/27, 7/28, 7/30, 7/31, 8/2, 8/3, 8/5, 8/6, 8/7, 8/8, 8/9, and 8/10 (14 of 19 weights were not obtained). Further, on 8/4/24 Resident #38 weighed 121.6 lbs., and on 8/12/24, Resident #38 weighed 113.1 lbs., an 8.5 lbs. loss which represents a 7.07% loss. Interview with LPN #1 on 8/12/24 at 11:41 AM identified that she was not aware that Resident #38 had an order for daily weights and it was not being completed because the 11:00 PM - 7:00 AM nurse aide would usually complete the weight, and the night shift charge nurse would enter the weight into the computer. LPN #1 further identified that Resident #38's weight loss was not communicated to her in report, but she had completed a reweight to confirm accuracy, and would notify the physician and resident representative of the weight loss. Interview with the RN Supervisor (RN #2) on 8/12/24 at 12:06 PM identified that she would expect Resident #38 to be weighed daily, per the physician's order. RN #2 further identified that weights are typically completed on the 11:00 PM - 7:00 AM shift, but when all the residents get their monthly weights, all shifts help with the task. Interview with LPN #3 on 8/13/24 at 7:08 AM identified that she was aware of the order for daily weights but on the nights that she was working, and the weights were missed, Resident #38 was most likely sleeping, and she didn't want to wake the resident up. LPN #3 further identified that she did not notify anyone that weights were missed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 8/13/24 at 10:30 AM failed to identify that Resident #38's weights were completed daily. The DNS indicated that it is her expectation that weights are completed per the physician's order. The facility's Weight Monitoring policy directs that residents will be weighed weekly for 4 weeks, on admission and readmission, and then monthly, unless otherwise indicated by the physician's order and/or recommended by the Registered Dietitian.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on observation, review of facility documentation, facility policy and interviews the facility failed to ensure a record of receipt and disposition of controlled drugs brought into the facility from an outside pharmacy in pill bottles, in sufficient detail to enable an accurate reconciliation. The findings include: Interview with the DNS on 8/12/24 at 9:25 AM identified discontinued controlled drugs are stored in a locked file cabinet in her office until destroyed. The DNS further identified the office door acts as the second lock for the controlled drugs being stored there. Observation on 8/12/24 at 10:50 AM identified the DNS's office door was wide open with no staff in the office. Subsequent to surveyor request, the DNS was paged to the office and arrived in approximately 5 minutes. During this time, no staff were in the office, which was open. Upon entry into the office, the DNS was asked to open the file cabinet where the discontinued controlled drugs were stored. The DNS walked over to a bag in the office, approximately 2 feet from the file cabinet, and obtained a lanyard that was hanging out of the bag and visible to anyone in the office. Attached to the lanyard was the key to the file cabinet containing the controlled drugs, which had only 1 lock. Upon opening the drawer of the file cabinet, a large number of controlled drugs, including blister packs, pill bottles and liquids were observed. The DNS and Regional Clinical Nurse (RCN) identified that there were 2 controlled drugs in the drawer, which were contained in pill bottles and had been brought into the facility from an outside pharmacy, that did not have reconciliation forms. Observation of the pill bottles and count of the number of pills identified the following. Tramadol 50 mg: 3 tablets remaining, and Clonazepam 1mg: 43 tablets remaining. After a search for the absent reconciliation forms for the Tramadol and Clonazepam, the facility provided a facility Resident Medication Sheet with the resident's name and Clonazepam 1 gm written on the top (the pill bottle label indicated the medication was Clonazepam 1mg, not 1gm). All other areas of the form were blank. The form did not identify sufficient detail to allow reconciliation specifying the name and correct strength of the medication, or the quantity and date received. Further, there was a yellow Post-it stuck to the front of the form. The Post-it contained the following information. Gave one, a first initial and last name, 8:15 PM, count 44. Additionally, the form identified gave one, an unreadable signature, 8:55 PM, count 43. The Post-it did not identify sufficient detail to allow reconciliation specifying the name and strength of the medication, the quantity and date received, or the resident's name. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, the facility contacted the nursing supervisor, RN #7 (who no longer worked for the facility) who admitted the 2 residents who brought the controlled drugs Tramadol and Clonazepam into the facility from an outside pharmacy. The facility provided an email from RN #7 dated 8/20/24 in which RN #7 indicated that the resident who brought the Tramadol was admitted on ,d+[DATE] with Tramadol 3 tabs which were stored behind 2 locked doors. Further, RN #7 wrote in the email the resident who brought in the Clonazepam was admitted on ,d+[DATE] with 45 Clonazepam which were also stored behind 2 locked doors. Observation and review of facility documentation identified there had been no reconciliation forms for the Tramadol and Clonazepam since April of 2024. The Inventory Control of Controlled Substances policy directs the facility should ensure the incoming and outgoing nurses count all Schedule II controlled substances and other medications with the risk of abuse or diversion at the change of each shift or at least once daily, and document the results on a controlled substance count verification/shift count sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policy, and interviews for 1 resident (Resident #40) reviewed for antibiotic use, the facility failed to ensure adequate indication for the prophylactic use of an antibiotic. The findings include: Resident #40 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, history of falls, and dementia. A physician's order dated 3/6/23 directed to administer 50mg Doxycycline, 1 tablet by mouth, in the evening. The nurse's note dated 3/6/23 through 3/31/23 failed to identify an indication for prophylactic antibiotic use or a chronic skin condition. Review of the physician's progress notes dated 3/7/23 through 3/31/23 failed to identify an indication for prophylactic antibiotic use or a chronic skin condition. The quarterly MDS dated [DATE] identified Resident #40 had severely impaired cognition, was taking an antibiotic with no indication noted, and failed to identify a skin problem. An APRN note dated 6/14/24 at 2:18 PM identified Resident #40 had chronic impetigo: has not had any episodes while at the facility, Doxycycline 50 mg daily (prescribed from dermatology). The care plan dated 6/17/24 failed to identify a care plan for prophylactic antibiotic use or a chronic skin condition. A physician's order dated 6/18/24 directed to administer 50mg Doxycycline, 1 tablet by mouth, in the evening, for prophylaxis. Interview and review of the clinical record with the Infection Control Nurse (RN #1) on 8/12/24 at 9:53 AM failed to identify progress notes or consultation notes indicating why Resident #40 was receiving a prophylactic antibiotic. RN #1 indicated that she would need to research the clinical record further. A nurse's note dated 8/12/24 at 1:54 PM identified a call was placed to the Dermatologist, the resident has been on long term use of Doxycycline for prevention of a bacterial skin infection. This has since resolved and the resident representative said Resident #40 has Rosacea, but that has also improved. New order: discontinue Doxycycline. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and review of the clinical record with RN #1 at 8/13/24 at 8:52 AM identified that she was unaware that Resident #40 had been taking a prophylactic antibiotic and normally there would be an indication for the medication listed on the order. RN #1 indicated that Resident #40 has a chronic problem, Rosacea, since admission, and that he/she had periodically gone to Dermatology appointments, with his/her representative, while a resident at the facility; however, a consultation report(s) from the Dermatologist was unable to be located. RN #1 identified that she called the Dermatologist, the facility physician, and resident representative on 8/12/24 and received an order to discontinue the Doxycycline. RN #1 indicated that it was not uncommon for someone with a chronic skin condition to be taking a low dose of Doxycycline, and in Resident #40's case, the Dermatologist had not indicated a stop date for the medication. Interview with the Dermatology Consultant's Office Manager on 8/13/24 at 9:56 AM identified Resident #40 had been a patient with the office for over [AGE] years, but had not been seen by the provider since 2022. The Dermatology Consultant's Office Manager further identified that Resident #40 was taking Doxycycline intermittently, since 1998, for Rosacea flare-ups and it had been more than 2 years (5/11/22) since he/she received the last refill for 50mg of Doxycycline, by mouth daily, for 90 days. The Dermatology Consultant's Office Manager further identified that Resident #40 had an appointment scheduled on 3/2/23 but it was canceled through the answering service and was never rescheduled. Interview with the DNS on 8/13/24 at 10:37 AM identified that she would expect there to be a diagnosis or specific indication for use when ordering a prophylactic antibiotic. Although attempted, an interview with MD #1 was not obtained. The Antibiotic/Antimicrobial Stewardship policy directs the facility to treat residents meeting the criteria for symptomatic infections only and enhance and strengthen the antibiotic stewardship program to decrease and minimize the inappropriate use of antimicrobials and simultaneously improve patient care outcomes and reduce possible consequences of antimicrobial use. The antimicrobial stewardship team will review antibiotic usage, MDRO data, and antibiotic usage audit tool results and provide feedback at the quarterly medical staff meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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. 46040 50890 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to store controlled drugs in a separately locked permanently affixed compartment, failed to limit access to the stored controlled drugs, failed to ensure drugs were stored at proper temperatures, including vaccines, and failed to label over the counter drugs with an open date per the facility policy. The findings include: 1. Interview with the DNS on 8/12/24 at 9:25 AM identified discontinued controlled drugs are stored in a locked file cabinet in her office until destroyed. The DNS further identified the office door acts as the second lock for the controlled drugs being stored there. Observation on 8/12/24 at 10:50 AM identified the DNS's office door was wide open with no staff in the office. Subsequent to surveyor request, the DNS was paged to the office and arrived in approximately 5 minutes. During this time, no staff were in the office, which was open. Upon entry into the office, the DNS was asked to open the file cabinet where the discontinued controlled drugs were stored. The DNS walked over to a bag in the office, approximately 2 feet from the file cabinet, and obtained a lanyard that was hanging out of the bag and visible to anyone in the office. Attached to the lanyard was the key to the file cabinet containing the controlled drugs, which had only 1 lock. Upon opening the drawer of the file cabinet, a large number of controlled drugs, including blister packs, pill bottles and liquids were observed. Interview with the DNS and RCN on 8/12/24 at 10:50 AM identified the office door should not have been left open. The DNS stated she did not think about the door over the last 2 days with everything going on and identified she was trained to keep the door closed and locked to act as a second lock for the controlled drug storage. The DNS further indicated she should have carried the key on her person rather than leaving the key in the office near the file cabinet. The following controlled drugs were stored in the cabinet in the DNS office. Oxycodone 5mg: 23 tablets. Tramadol 25mg: 7 half- tablets. Tramadol 50mg: 13 tablets. Lorazepam 0.5mg: 26 tablets. Tramadol 25mg: 24 half- tablets. Tramadol 50 mg: 85 tablets. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Oxycodone 10mg: 30 tablets. Oxycodone 5mg: 23 tablets. Tramadol 50mg: 5 tablets. Oxycodone 10mg: 30 tablets. Tramadol 25mg: 24 half- tablets. Tramadol 50mg: 25 tablets. Oxycodone 5mg: 29 tablets. Diazepam 5mg: 10 tablets. Morphine Sulfate 100mg/5ml: 30ml. Lorazepam 2mg/1ml: 30ml. Morphine Sulfate 20mg/5ml: 20ml. Morphine Sulfate 100mg/5ml: 30ml. Tramadol 50mg: 6 tablets. Hydrocodone-acetaminophen 5-325mg: 24 tablets. Morphine Sulfate 100mg/5ml: 30ml. Morphine Sulfate 100mg/5ml: 26ml. Interview on 8/12/24 at 11:46 AM with the DNS identified she is in the process of being trained on narcotic destruction. The DNS identified when she was hired 8 weeks prior, the same file cabinet was full of controlled drugs. At that time, the DNS and RCN destroyed the controlled drugs. The DNS stated she has not destroyed controlled drugs since. Subsequent to surveyor inquiry, the facility permanently affixed the file cabinet, used for storing discontinued controlled drugs, to the wall, and added a second lock. The Storage and Expiration Dating of Medications and Biologicals policy directs that the facility should store all drugs and biologicals in locked compartments, including the storage of Scheduled II - V medications in separately locked, permanently affixed compartments, permitting only authorized personnel to have access. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	2. During a medication administration observation on 8/11/24 at 7:47 AM LPN #1 poured a Vitamin B1 pill from a pill bottle in the medication cart. When viewed, the pill bottle lacked an open date. Subsequently, LPN #1 pulled multiple additional over the counter pill bottles from the top drawer of medication cart #1, all of which were opened, in use, and missing open dates. The following open medication bottles lacked open dates: Vitamin B1, Magnesium, Mag Ox, Bisacodyl, Vitamin D3, Vitamin D, Benadryl, and Fexofenadine. Additionally, multiple over the counter drugs were observed to have incomplete open dates: Medication cart #1: Vitamin D3: open date 8/2, Vitamin B12: open date 7/29, Folic Acid: open date 7/20. Medication cart #2: Folic Acid: open date 8/8, multi-vitamin: open date 8/1. Interview with the DNS on 8/12/24 at 12:24 PM identified all over the counter medications should be dated with an open date and discarded after 30 days. The DNS indicated the date should include a day, month and year. The Storage and Expiration Dating of Medications and Biologicals policy directs facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. 3. During the medication room observation on 8/12/24 at 6:30 AM the following medications were stored in the medication room refrigerator. Medication refrigerator temperatures could not be reviewed as there was no medication refrigerator temperature log that could be found at that time. Intravenous (IV) Vancomycin 1 gm: 4 bags (store at 41 degrees F per manufacturer recommended storage temperatures). IV Ceftriaxone 2gm: 1 bag store at 41 degrees F per manufacturer recommended storage temperatures). Spikevax 2.5ml: 5 vaccines (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). Tuberculin 1ml: 2 vials (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). Prevnar 20 0.5ml: 3 vaccines (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). Latanoprost 0.005% drops: 1 bottle (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). Lantus 100unit/1ml: 5 pens (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). Basaglar Insulin: 1 pen (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Lorazepam 30ml: 1 bottle (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). Lorazepam 1ml: 5 vials (store at 36 - 46 degrees F per manufacturer recommended storage temperatures). The off going registered nurse supervisor (RN #6) located a facility document titled (Temperature Log for Refrigerator) with the month/year section filled out as: August 2024. The August 2024 temperature log was blank. The directions on the form direct to monitor temperatures twice a day and to label any vaccines exposed to temperatures outside of the indicated range as do not use. Interview with RN #6 on 8/12/24 at 6:35 AM identified third shift nurses are responsible for monitoring the temperature of the medication refrigerator in the medication room. RN #6 did not know why the temperature log was blank. Interview with registered nurse supervisor (RN #2) on 8/12/24 at 10:00 AM identified third shift is responsible for monitoring medication refrigerator temperatures. RN #2 referenced a binder titled Glucometer/med fridge temps/chores. The binder was reviewed, and no temperature logs were present. A medication room observation on 8/13/24 at 6:45AM identified no temperature log in the medication room. Interview with the off going registered nurse supervisor (RN #8) on 8/13/24 at 6:45 AM identified the third shift nurses should monitor medication refrigerator temperatures. RN #8 was unable to locate the temperature logs. The facility was unable to provide refrigerator temperature logs for the medication room refrigerator from March 2024 through July of 2024. Interview with the DNS on 8/13/24 at 11:25 AM identified she was unaware of a process for monitoring medication room refrigerator temperatures. The Storage and Expiration Dating of Medications and Biologicals policy directs the facility staff should monitor the temperature of vaccines twice a day per CDC guidelines and should monitor the temperature of medication storage areas at least daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50890 Based on observation, review of facility policy, and interviews for 2 of 3 residents (Resident #308 and resident 307) reviewed for medication administration observation, the facility failed to ensure licensed staff performed hand hygiene during medication administration and failed to ensure nurse aides performed hand hygiene prior to providing resident care and after removing gloves. The findings include: 1. During a medication administration observation on 8/11/24 at 7:47 AM, LPN #1 failed to perform hand hygiene during the entirety of the observation to include: before preparing medications for Resident #308, after going into the medication room to retrieve additional medications, before administering medications to Resident #308, after administering medications to Resident #308, before preparing medications for Resident #307, before administering medications to Resident #307 and after administering medications to Resident #307. An interview with LPN #1 on 8/11/24 at 8:45 AM identified she did not wash her hands during medication administration because she forgot to do so. 2. During an observation on 8/11/24 at 9:25 AM, NA #1 was observed walking in and out of 4 resident rooms (rooms: 214, 213, 212, 211) collecting dirty dishes, and clearing uneaten food into a bin on a cart in the hallway. NA #1 did not perform hand hygiene between resident rooms. Further, without the benefit of hand hygiene, NA #1 entered Resident #6's room, removed and discarded her dirty gloves in a trash can near the room entryway, did not perform hand hygiene, and proceeded directly to Resident #6's bedside. NA #1 then assisted Resident #6 with upper body positioning and adjusted the bed linens. 3. During an observation on 8/11/24 at 9:41 AM, NA #1 was observed walking in and out of 5 resident rooms (rooms: 209, 208, 207, 206, 205) collecting dirty dishes, and clearing uneaten food into a bin on a cart in the hallway, without performing hand hygiene between resident rooms. NA #1 then entered Resident #13's room, with the same dirty gloves on, opened the bathroom door, looked inside the bathroom, then walked over to the residents tray table, moved the tray table and wiped a spill off the tray table. NA #1 then returned to the dirty dish cart wearing the same dirty gloves. An interview with NA #1 on 8/11/24 at 9:45 AM identified she changes her gloves after removal of all dirty dishes, not in between rooms. NA #1 indicated she should have removed her gloves and performed hand hygiene before touching surfaces in Resident #13's room but did not know if she should have performed hand hygiene after removing her gloves and assisting Resident #6. Subsequent to surveyor inquiry, NA #1 continued down the hallway, pushing the dirty dish cart with unchanged dirty gloves on and proceeded into the lounge to continue clearing dirty dishes. An interview with the Director of Nursing (DNS) on 8/12/24 at 12:24 PM identified hand hygiene should be performed before and after entering resident rooms and before and after administering medications. The DNS further indicated staff are expected to perform hand hygiene after removing gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Handwashing policy directs to perform hand hygiene before preparing or handling medications, before and after resident contact, and after removing gloves.