STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075345	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews and review of the Payroll Based Journal (PBJ) submissions, the facility failed to provide the appropriate number of weekend staff for Quarter 3 and Quarter 4 of Fiscal Year 2024 (April 1, 2024 through September 30, 2024) and Quarter 1 and Quarter 2 of Fiscal Year 2025 (October 1, 2024, through March 31, 2025). The findings include:PBJ submissions for Quarter 3 and Quarter 4 of Fiscal Year 2024 and Quarter 1 and Quarter 2 of Fiscal Year 2025 (April 1, 2024, through March 31, 2025) indicated the facility had triggered for excessively low weekend staffing.Interview and review of documentation with the Director of Nursing (DNS) on 8/1/25 at 3:37 PM identified that although she was not working at the facility for most of the time the PBJ submissions had triggered for excessively low weekend staffing (4/1/24-3/31/25) she was aware the facility had a low staffing problem on the weekends. The DNS indicated although the facility had staff call outs and general low staffing at that time, the facility recently had a massive hiring event and should see a change in the next few weeks because all open positions had been filled. The DNS identified the HR staff who was responsible for PBJ submissions was not working or available this week. Interview and review of documentation with the Administrator on 8/4/25 at 1:56 PM identified she was not aware of the facility triggering for excessively low weekend staffing (4/1/24-3/31/25) because she was not employed by the facility until a few weeks ago. The Administrator indicated Human Resources (HR) had been recruiting and hiring extensively and the facility had also stopped using agency staff in the last month or so. The Administrator identified staff call outs on the weekend could have contributed to the low staffing and when call outs happen now, efforts are made to ask other staff to stay, offer staff bonuses or contact staff from a shared staff list to help cover the shortage. The Administrator also indicated the HR person responsible for PBJ submissions was not working or available this week.Interview and review of documentation with the facility scheduler on 8/4/25 at 2:04 PM identified that although she was not working at the facility at the time the PBJ submissions had triggered for excessively low weekend staffing (4/1/24-3/31/25), she was aware of some of the quarters but not all of them. The facility scheduler identified that due to more call outs on the weekends there would have been less staff available to work during that time but since they have since hired more staff, the weekend staffing has been better. Review of the Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Reporting Long Term Care Facility Policy Manual, dated June 2022, directed Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information. Additionally, it identified that facilities that do not meet requirements will be considered noncompliant and subject to enforcement actions by CMS.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 1 of 1 sampled residents identified to self administer medication (Resident #45), the facility failed to assess Resident #45's ability to safely self-administer Insulin. The findings include: Resident #45's was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus, end stage renal disease, and dependence on renal dialysis. An Inter-Agency Referral form (W-10) from the hospital and dated 2/26/25, indicated Resident #45 was ordered Humulin R U-500 KwikPen (an intermediate acting insulin to lower blood glucose), 25 units at breakfast, and 40 units at lunch, and 55 units at dinner. A Resident Care Plan dated 2/27/25 identified a diagnosis of diabetes with Resident #45 being at risk for hyperglycemia/hypoglycemia and other complications. Interventions included administration of medications as ordered, completion of fingerstick as ordered, and watching for acute signs of hyperglycemia. Physician's orders dated 2/26/25 and currently in effect directed staff to check Resident #45's fasting blood sugar three times daily before meals for diabetes mellitus. Physician's orders dated 2/27/25 and currently in effect directed Humulin R U-500 KwikPen 25-unit injections subcutaneously in the morning for diabetes mellitus after breakfast, and that the resident was approved to keep insulins at bedside to self-administer. Physician's orders dated 2/27/25 directed Humulin R U-500 KwikPen 40-unit injections subcutaneously in the afternoon for diabetes mellitus after lunch, and Humulin R U-500 KwikPen 55-unit injections subcutaneously in the evening for diabetes mellitus after dinner. Neither the afternoon nor the evening instructions directed self-administration. There was no documentation of a nursing assessment for Resident #45's competence to self-administer Insulin before or after these orders. An admission Minimum Data Set (MDS) assessment dated [DATE], identified Resident #45 was cognitively intact and independent with activities of daily living. The MDS also indicated that Resident #45 had been administered Insulin in the prior seven days and was currently administered a high-risk medication. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #45 was cognitively intact and independent with activities of daily living. The MDS indicated that Insulin had been administered in the prior seven days and was currently administered high-risk medications as part of his/her care. The Advanced Practice Registered Nurse progress note dated 7/2/25 through 8/1/25 failed to include documentation related to Resident #45's ability to self-administer Insulin. Interview with Resident #45 on 7/28/25 at 11:45 AM indicated that he/she self-administers Insulin, kept the Insulin in his/her room, and monitored his/her own blood glucose levels independently. Further review of the medical record failed to indicate Resident #45 was assessed to safely store and administer Insulin to his/herself and self-perform blood glucose testing. Observations of Resident #45's room at 7/28/25 at 11:45 AM identified his/her Insulin pen, unsecured on his/her bedside table. Interview with Resident #45 on 7/30/25 at 9:50 AM indicated that the resident's family member provided the Insulin to the resident directly from the pharmacy, without additional verification by facility staff. Review of the Medication Administration Record (MAR) dated May 1, 2025, through July 31, 2025, indicated multiple incidences of nursing documenting resident refusal of blood glucose monitoring and administration of Insulin, with a sub-note that the resident self-managed or self-administered the Insulin. Nursing notes dated 7/19/25 at 3:10 PM indicated Resident #45 stated he/she would administer Insulin when he/she decided to eat and if he/she felt the need. An interview and clinical record review with the Director of Nursing Services (DNS) on 7/31/25 at 11:45 AM, indicated that the DNS was not aware that Resident #45 was keeping his/her Insulin at the bedside or that he/she was self-administering. Additionally, review of the clinical record with the DNS failed to reflect that Resident #45 had been assessed for self-administration of medications and further identified a blank Self-Administration of Medications Assessment form that was present in the electronic health record. Furthermore, the DNS indicated that Resident #45 had not been assessed for self-performing and (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	monitoring of blood glucose. On 7/31/25 at 12:23 PM, subsequent to surveyor inquiry, the DNS completed a self-administration assessment with Resident #45. Additionally, on 8/1/25 at 11:50 AM, subsequent to surveyor inquiry, the DNS provided Resident #45 with a lockbox to continue to keep his/her Insulin at the bedside and the ability to self-administer Insulin as ordered. Review of the facility policy Self Administration of Medications, directed, in part, that residents may self-administer medications if it is determined to be safe and appropriate based on an individual assessment conducted by a licensed nurse. The facility will evaluate the resident's ability to self-administer medications independently and review this determination as needed to ensure continued safety. The procedure indicates the following: (1) that the assessment will include evaluating the resident's understanding of their medication regimen and ability to store and take medications properly; (2) The results of the assessment must be documented in the resident's medical record; (3) Resident's approved for self-administration must store medications securely as directed by facility policies to prevent misuse of accidental exposure.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interviews, review of employee personnel records and facility policy and interviews for 4 of 5 employees (Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #3, Nurse Aide (NA) #3 and NA #9), the facility failed to ensure pre-employment references were obtained. The findings include:1. RN #1's date of hire was 9/7/23. No pre-employment references were obtained or located in the employee's personnel file. Although requested, the facility could not provide pre-employment references for RN #1. Review of the facility staffing schedules and time records indicated RN #1 currently worked at the facility. 2. LPN #3's date of hire was 10/3/24. No pre-employment references were identified in the employee's personnel file. Although requested, the facility could not provide pre-employment references for LPN #3. Review of the facility staffing schedules and time records indicated LPN #3 currently worked at the facility. 3. NA #3's date of hire was 7/9/24. No pre-employment references were identified in the employee's personnel file. Although requested, the facility could not provide pre-employment references for NA #3. Review of the facility staffing schedules and time records indicated NA #3 currently worked at the facility. 4. NA #9's date of hire was 9/7/22. No pre-employment references were identified in the employee's personnel file. Although requested, the facility could not provide pre-employment references for NA #9. Review of the facility staffing schedules and time records indicated NA #9 currently worked at the facility. Interview and review of facility documentation with the DNS on 8/4/25 at 10:30AM identified that she was unable to locate pre-employment references for RN #1, LPN #3, NA #3 and NA #9. The DNS indicated that although she was not employed at the facility when RN #1, LPN #3, NA #3 and NA #9 were hired, the facility did not obtain pre-employment references before their hire and should have. The DNS further identified that per review of the facility staffing schedules and time records RN #1, LPN #3, NA #3, and NA #9 currently worked at the facility. Interview and review of documentation with the regional nurse (RN #7) on 8/4/25 at 11:10 AM identified that she was unable to locate pre-employment references for RN #1, LPN #3, NA #3, and NA #9 and she thought they were no longer required. Review of federal regulations at F 606 with RN #7 indicated pre-employment references were still required. Review of the facility policy, Abuse, undated, failed to indicate the required pre-employment references would be obtained under the screening (pre-hire) of new employees.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, interviews, and facility policy for 1 of 4 sampled residents (Resident #3) reviewed for accidents, the facility failed to ensure a call bell was in reach per the Resident Care Plan (RCP) which resulted in a fall and for 1 of 2 sampled residents (Resident #84) reviewed for position/mobility and respiratory care, the facility failed to ensure the care plan was comprehensive to include a diagnoses with interventions for quadriplegia and respiratory care. The findings include: 1.Resident #3's diagnoses included Parkinson's disease, orthostatic hypotension, and a history of falling. The Resident Care Plan (RCP) dated 6/5/25 identified Resident #3 was a fall risk and required assistance with activities of daily living. Interventions included to keep the call bell within reach when the resident was in bed or in the bedside chair, encourage the resident to ask and wait for staff assistance for transfers and toileting, and set-up and assist the resident as needed. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired and required extensive assistance with bed mobility, toileting, and transfers. The MDS further indicated Resident #3 had Parkinson's Disease and orthostatic hypotension with a history of a fall. A physician's order dated 7/1/25 directed Resident #3 was a stand/pivot transfer only until orthostatic hypotension improved and may sit in a chair. A facility Reportable Event form (RE) completed by Licensed Practical Nurse (LPN) #11 and dated 7/1/25 at 6:20 PM identified Resident #3 was observed on the floor next to his/her bed. The RE indicated Resident #3 had no injuries and the incident was unwitnessed. The RE directed post fall actions were to keep the call bell clipped to the residents bedding. A facility Interdisciplinary Fall Assessment (IFA) form completed by LPN #11 and dated 7/1/25 identified Resident #3 had an unwitnessed fall and was found on the floor next to the bed. The IFA indicated Resident #3 stated he/she was trying to find the red button and the call bell was not in reach. The IFA further identified Resident #3 had 7 falls in the last 30 days. A facility Fall Scene Investigation (FSI) form completed by LPN #11 and dated 7/1/25 identified Resident #3 was in the wheelchair prior to the unwitnessed fall and the call light was not in reach of the resident. The FSI indicated the resident stated he/she was trying to get up to find the red button. A post fall intervention on the FSI directed to place the resident's call bell in reach. A nursing note dated 7/1/25 at 6:47 PM identified Resident #3 was observed on the floor in his/her room and stated he/she slipped on the floor trying to get up from his/her recliner chair and had no visible injuries. The nursing note indicated neurological assessments were in place and the family was informed. An interview with Nurse Aide (NA) #6 on 8/1/25 at 9:25 AM identified she was assigned to Resident #3 when the resident fell on 7/1/25. NA #6 indicated the resident was found on the floor next to the bed and she was pretty positive the resident had his/her call bell in reach but was unable to recall for sure because it was a while ago. NA #6 identified Resident #3 was seated in the bedside chair prior to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the fall and although Resident #3 was antsy and wanted the call bell all the time, after the resident's fall on 7/1/25, she made sure the resident's call light was within reach at all times. Interview and review of the clinical record with the DNS on 8/4/25 at 11:50 AM identified it was the responsibility of the nurse or NA to ensure Resident #3 always had his/her call light in reach. Review of facility documentation with the DNS indicated the fall on 7/1/25 was a result of the resident not having his/her call light in reach. The DNS identified she was unsure why Resident #3 did not have his/her call light in reach when he/she fell on 7/1/25 since the resident had multiple falls while at the facility. Additionally, the DNS indicated it was a standard of practice to keep a resident's call light within reach at all times. Multiple attempts to interview LPN #11 were unsuccessful. Review of the facility policy, Call Bells, undated, directed the facility would ensure resident's needs are met by maintaining availability of call bells and call bells should be positioned so that residents can easily access them when needed. Review of the facility policy regarding Falls, undated, directed the facility would identify residents at risk for falls and implement interventions to minimize falls and related injuries. In addition, the policy directed the facility would develop and revise interdisciplinary care plans to address fall and injury risk and inform ongoing prevention strategies. 2.Resident #84 had diagnoses that included quadriplegia, obstructive sleep apnea (OSA), and morbid obesity. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #84 was cognitively intact, used a motorized wheelchair, had functional limitation in range of motion of his/her upper extremities (shoulder, elbow, wrist, hand) on both sides, and had functional limitation in range of motion of his/her lower extremities (hip, knee, ankle, foot) on both sides. The assessment identified Resident #84 was dependent for eating, bed mobility, transfer, and for wheelingl his/her motorized wheelchair. The Resident Care Plan (RCP) dated 4/21/25 identified Resident #84 required staff assistance with activities of daily living (ADLs) (basic self-care tasks performed regularly including bathing, dressing, toileting, eating, walking, transferring, managing bowel and bladder functions, and grooming). Interventions included to provide assistance with feeding as needed, incontinent care per policy, and keep commonly used/needed articles within reach. The RCP failed to identify Resident #84 required total staff assistance with all ADLs (as per the MDS). a. Review of the RCP dated 4/21/25 failed to identify development of a care plan related to Resident #84's diagnosis of quadriplegia. Resident #84 required total staff assistance with all ADLs related to his/her quadriplegia. Resident #84 required the use of a specialized call bell to request assistance from staff. Interview with Registered Nurse (RN) #8 and Licensed Practical Nurse (LPN) #6 on 7/31/25 at 3:30 PM identified Resident #84 should have a person-centered care plan for quadriplegia as identified in his/her active diagnoses in the admission MDS assessment dated [DATE]. RN #8 and LPN #6 identified the RCP should identify that Resident #84 was dependent for all areas of functional mobility related to his/her diagnosis of quadriplegia. RN #8 and LPN #6 further identified Resident #84's RCP (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	should include person-centered interventions related to his/her quadriplegia such as the specialized call bell that he/she activated using his/her chin when staff assistance was needed, and that Resident #84 required assistance of 2 to 3 staff members for incontinent care, transfers, and mobility. RN #8 and LPN #6 further identified Resident #84's RCP included interventions that were not person-centered for a resident with quadriplegia such as I use a wheelchair for mobility. I am able to propel on my own for short distances., Please set me up at my bedside or in the bathroom and allow me to do what I can for myself, and then assist me with the rest., and Encourage me to ask for and wait for staff assistance with transfers. Subsequent to surveyor inquiry the RCP dated 8/4/25 identified Resident #84 was unable to move all extremities related to a diagnosis of quadriplegia. The RCP further identified Resident #84 was able to move his/her head side to side, and up and down, used a soft touch call bell positioned at his/her neck, and required total staff assistance with all ADLs. Interventions included assist with feeding as needed, incontinent care per policy, and keep commonly used/needed articles within reach. The RCP failed to identify interventions specifically related to Resident #84's quadriplegia which included proper positioning of his/her extremities, placement of hand splints, direction to not place a pillow under his/her head unless requested by Resident #84. b. Review of the RCP dated 4/21/25 failed to identify development of a care plan focus related to Resident #84's diagnosis of OSA. Resident #84 used a continuous positive airway pressure (CPAP) machine (delivers constant and steady air pressure to help you breathe while you sleep). Additionally, Resident #84 used oxygen therapy via a nasal cannula when out of bed to his/her wheelchair. Interview with Registered Nurse (RN) #8 and Licensed Practical Nurse (LPN) #6 on 7/31/25 at 3:30 PM identified Resident #84 should have a care plan for OSA as identified in his/her active diagnoses in the admission MDS assessment dated [DATE]. RN #8 and LPN #6 further identified Resident #84 should have interventions related to use and cleaning of his/her CPAP machine, and use of oxygen therapy via nasal cannula when out of bed to his/her wheelchair. Subsequent to surveyor inquiry the RCP dated 7/31/25 identified Resident #84 used a CPAP machine related to OSA. Interventions included for staff to ensure the CPAP nasal prong was secure and comfortable, and to clean the CPAP per orders. The RCP failed to identify Resident #84 required oxygen therapy when out of bed to his/her wheelchair. Review of the Care Planning policy directed, in part, a comprehensive and individualized plan of care will be developed for each resident based on the identified needs, strengths and preferences of the resident. The policy directed the care plan will include a statement of the problem/focus and interventions to achieve these goals. The policy further directed the resident care cards will be updated as needed to reflect changes made to the resident's plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews, review of the clinical record, facility documentation, and facility policy for 4 of 4 residents (Resident #5, Resident #28, Resident #31 and Resident #41) reviewed for care planning, the facility failed to complete quarterly, interdisciplinary resident care plan meetings. The findings include: 1. Resident #5 had diagnoses that included obstructive and reflex uropathy (blockage in the urinary tract), hypotension (low blood pressure), and prostate cancer. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was cognitively intact, had an indwelling catheter, was independent with eating, required substantial/maximal assistance with bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 7/31/24 identified Resident #5 had a suprapubic tube due to obstructive uropathy, and he/she was at risk for a urinary tract infection (UTI). Interventions included to observe urine for color, clarity and odor and report any abnormalities to the physician, and perform suprapubic tube site care per physician orders. Review of Resident #5's Resident Care Plan signature sheet identified quarterly care plan meetings were not held/conducted since 12/10/24. 2. Resident #28 had diagnoses that included chronic obstructive pulmonary disease (COPD), dementia, and epilepsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 was moderately cognitively impaired, independent with eating, required supervision or touching assistance with bed mobility and required substantial/maximal assistance with chair/bed transfers. The Resident Care Plan dated 9/19/24 identified Resident #28 had impaired cognition with impaired memory, recall and decision making skills related to dementia. Interventions included use short, simple sentences and offer support and reassurance if Resident #28 appears anxious. Review of Resident #28's Resident Care Plan signature sheet identified quarterly care plan meetings were not held/conducted since 12/12/24. Interview and facility documentation review with the MDS Coordinator/Licensed Practical Nurse (LPN) #6 and Registered Nurse (RN) #8 on 7/31/25 identified that resident care plan meetings should be held quarterly. LPN #6 identified the receptionist mailed out invites for the care plan meetings to the family/responsible party, and that LPN #6 or one of the other MDS coordinators would notify the resident of the upcoming care plan meeting. LPN #6 indicated that per the facility documentation kept in a binder in the MDS coordinator office but failed to identify why quarterly care plan meetings had not been completed since 2024. Interview, record review, and facility documentation review with the Regional MDS Coordinator RN #9 and MDS Coordinator RN #10 on 8/1/25 at 10:10 AM identified resident care plan meetings should be held quarterly with the interdisciplinary team (IDT). RN #10 identified the IDT consisted of the MDS coordinators, social worker, physical therapy, dietician, recreation, the resident or the resident's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible party if cognitively impaired, and sometimes the unit nurses if available. RN #9 identified the responsible party was notified by mail 2 weeks in advance of the meeting and if no response to the letter was received, the MDS coordinators would attempt to contact them by phone. RN #10 identified it was the responsibility of the MDS coordinators and the social worker for ensuring the resident care plan meetings were conducted. RN #10 indicated that documentation of the care plan meetings was not done in the clinical record, but instead the meetings were documented on sign-in sheets that contained documentation of the areas reviewed in the meeting, and those sheets were filed in a binder that was kept in the MDS coordinator's office. 3.Resident #31's diagnoses included hemiplegia and hemiparesis following other cerebrovascular disease, anoxic brain damage, and localization-related idiopathic epilepsy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 had a short/long term memory problems and was dependent on staff for self-care and transfers. The Resident Care Plan (RCP) dated 5/29/24 identified Resident #31 had impaired memory, recall, and decision-making skills related to cerebrovascular incident and anoxic brain damage. Interventions included using short and simple sentences, offer support and reassurance if resident appeared anxious, and to offer one-step-at-a-time directions. Additionally, the RCP identified Resident #31 had difficulty understanding and/or expressing speech. Interventions included for staff to be patient and reassure as needed, keep communications simple, and to use gestures and other non-verbal techniques to enhance communication. Interview with Person #1 on 7/29/25 at 9:35 AM identified that the last time a care plan meeting was completed for Resident #31 was in November 2024 and that the social worker was the only staff member present for that meeting. Person #1 further identified that he/she was the resident representative and would like to continue to attend RCP meetings. Review of Resident #31's admission record identified Person #1 as the resident representative. Interview, record review, and facility documentation review with the Regional MDS Coordinator (RN #9) and the facility MDS Coordinator (LPN #6) on 8/1/25 at 10:09 AM identified that there should be a quarterly care plan meeting for residents with the Interdisciplinary Team (IDT). Further identifying that the IDT consisted of the MDS coordinators, social worker, physical therapy, dietary, recreation, resident representative if cognitively impaired, and unit nurses if available. RN #9 indicated that the resident representative was notified by mail two (2) weeks in advance of the RCP meeting and that if they do not respond to the letter, they will attempt contact by phone. LPN #6 identified that they do not document the meeting in the resident's electronic health record but do have sign-in sheets which contain documentation of the meeting and areas discussed in meeting. LPN #6 indicated that per the facility records, the last care plan meeting for Resident #31 was on 5/23/24. LPN #6 identified that it was the responsibility of the MDS Coordinators to ensure that the meetings take place quarterly. The interview failed to identify why quarterly care plan meetings had not been completed since 5/23/24. Interview with the Director of Nursing Services (DNS) on 8/1/25 at 11:02 AM identified that resident care plan meetings were to be conducted quarterly with the IDT and that it was the responsibility of the MDS Coordinators. The interview failed to identify the reason the quarterly care plan meetings were not conducted timely. 4.Resident #41's diagnosis included anxiety, hypertension, and psychoactive substance dependence (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder. The Resident Care Plan (RCP) dated 6/6/25 identified that Resident #41 was at risk for anxiety when other residents enter her/his room with interventions that included to place a stop sign across my door, psych and social services to follow up. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 was cognitively intact and independent for showering, transfers, eating and dressing. The Resident Care Plan sign in sheet for Resident Care Conference (RCC) identified care plan meetings were held on 7/11/23, 1/11/24, 3/26/24, 10/3/24, and 7/30/25 (quarterly care plan meetings were not held in October 2023, July 2024, January 2025, and April 2025). An interview on 7/31/25 at 1:54 PM with Social Worker #1 identified that Resident #41's last care plan meeting was held on 7/30/25 and any meetings before that was a long time ago. Also identifying the Minimum Data Set office would have a record of the dates of the meetings. An interview on 7/31/25 at 2:31 PM with Registered Nurse (RN) #9 identified the MDS office staffing has had staffing turn over within the last 4 months. Also identifying that a care plan meeting should occur within the first month of admission and then on a quarterly basis. Further identifying the record identified the Resident Care Conference was held on 7/11/23, 1/14/24, 3/6/24 ,10/3/24, 7/30/25 and she was unsure of the reason the meetings were not held quarterly as per the policy and that numerous meetings were not conducted. An interview on 7/31/25 at 2:44 PM with RN #5 identified that care plan meetings were to be held quarterly, and she was unsure of why the meetings were not held. Also identifying the administrator provides oversight but the current administrator just started a few weeks ago. Review of the facility care planning policy identified that the care plan is developed by the IDT in collaboration with the resident and/or family/responsible party and the resident's physician. The IDT may include, but is not limited to, the resident care coordinator, charge nurse, certified nurse assistant (CNA), dietary manager or dietician, social worker, rehab therapist, and activities director. Additionally, the policy indicated a care conference to discuss the plan of care will be held on or before day 21 from admission and then at least quarterly and that the resident and/or family/responsible party will be invited to attend all care plan conferences.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #5 and Resident #61) reviewed for urinary tract infections (UTI), the facility failed to ensure fluid intake to meet daily fluid goals for a resident with a urinary catheter and history of urinary tract infections. The findings include: 1. Resident #5 had diagnoses that included obstructive and reflex uropathy (blockage in the urinary tract), hypotension (low blood pressure), and prostate cancer.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was moderately cognitively impaired, had an indwelling catheter, was independent with eating, and was dependent with toileting hygiene, bed mobility, and transfers.The Resident Care Plan (RCP) dated 12/10/24 identified Resident #5 had a suprapubic tube (SPT) due to obstructive uropathy, and he/she was at risk for a urinary tract infection (UTI). Interventions included to observe urine for color, clarity, and odor and report any abnormalities to the physician, and perform SPT site care per physician orders.A Dietician note dated 6/3/25 at 11:43 AM identified Resident #5 was seen for his/her quarterly nutritional assessment. The note identified Resident #5's intake remains adequate with meal intake around 75 percent (%) to 100%. The note failed to reflect the estimated fluid goal and therefore did not identify if Resident #5 was meeting his/her fluid goals. Advanced Practice Registered Nurse (APRN) progress notes dated 7/15/25 at 8:45 AM identified Resident #5's urological management remained complex with recent complications that included catheter obstruction from sediment accumulation and hematuria which required intervention by Resident #5's urologist for catheter changes.A nursing note written by Licensed Practical Nurse (LPN) #12 on 7/23/25 at 5:20 AM identified Resident #5's SPT was flushed and was draining well, and fluid intake was encouraged. Review of Resident #5's Intake/Output Record dated 7/23/25 failed to document fluid intake on all 3 shifts/for 24 hours. Observation and interview with Resident #5 in his/her room on 7/28/25 at 12:23 PM identified Resident #5's SPT drainage bag had 300 milliliters (ml) of reddish colored urine within the bag. Resident #5 stated that he/she had a UTI which was uncomfortable.An APRN progress note dated 7/29/25 at 8:30 AM identified Resident #5 was seen after referral by nursing for hematuria. The note identified Resident #5 was due for routine replacement of his/her SPT this week, and it had been about 3 weeks since the previous catheter change. The note further identified Resident #5 agreed with increasing his/her oral fluid but failed to identify a quantative increase in fluid intake. An APRN order dated 7/29/25 directed to obtain/monitor vital signs in the morning for hematuria for 3 days.An APRN order dated 7/30/25 directed to encourage an additional 240 ml of fluids by mouth every shift for hypotension for 3 days, but the clinical record failed to identify fluid levels were increased because fluid intake was not recorded.Interview with Nurse Aide (NA) #1 and NA #2 on 7/31/25 at 8:15 AM identified that when they documented the food and drink intake for residents in the electronic medical record (EMR) it did not ask for them to enter an amount of liquid consumed. NA #1 and NA #2 identified that they would look inside the Intake & Output (I&O) binder at the nurse's station to see which residents were on I&O's, and it they saw a resident on their assignment in the book for the date they were working, they would document the amount of I&O's for those residents.Interview with LPN #8 on 7/31/25 at 12:10 PM identified that unless there was an order in the EMR for I&O's, she wouldn't know which residents were supposed to be on I&Os. LPN #8 further identified I&O's information was not on the nursing report sheets, and she didn't receive that information from the off-going nurse in report.Interview with APRN #1 on 8/1/25 at 9:00 AM identified when she wrote in a progress note enhanced fluid intake she meant for nursing staff to encourage fluids for that resident. APRN #1 identified she would often order an additional 240 ml of fluid every shift for 3 days or sometimes 5 days to give the resident a boost in fluid intake because she didn't see consistent documentation of fluid intake by the nursing staff, and by ordering the extra fluids each shift, she (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knew that the resident was getting at least that amount each shift. APRN #1 identified when she wrote an order for additional fluids she would verify the intake by talking with the nurses to see how the resident was doing with the extra fluid intake. When she wrote in her progress note enhance fluid intake protocol maintained she would verify that it was maintained by checking blood work, through her assessments, and by speaking with the nurses. APRN #1 stated it was hard to easily see the residents' fluid intake in the EMR or clinical record when doing rounds because she wasn't able to definitively see a documented amount of intake. APRN #1 further identified that Resident #5 was resistive sometimes with consuming adequate amounts of fluids and that she would order extra fluids for Resident #5, because it was important for him/her to maintain adequate fluid intake in order to maintain patency of his/her SPT by decreasing the sediment. An APRN progress note written by APRN #1 on 8/1/25 at 9:30 AM identified Resident #5 was seen for follow-up evaluation for sediment and hematuria in the SPT earlier that week. The note identified nursing staff were to monitor and record Resident #5's intake and output measurements to ensure Resident #5 was achieving appropriate fluid balance goals. The note identified Resident #5's clinical management had been modified to include increase frequency of catheter flushes and education to Resident #5 on the importance of increased oral fluid intake to meet his/her daily fluid goals. The note identified Resident #5 had been seen previously for evaluation of catheter-related complications which included sediment accumulation and hematuria that required interventions for management. The note identified Resident #5's hematuria had resolved following the change of his/her SPT and increased catheter flushes to 3 times a day were implemented. The note further identified that adequate hydration was important in preventing a recurrence.Review of Resident #5's Intake/Output Report sheet in the I&O binder on Wing 300 identified documentation of I&Os on 7/22/25, 7/23/25, 7/24/25, 7/25/25, 7/26/25, 7/27/25, 7/28/25, 7/29/25, 7/30/25, 7/31/25, and 8/1/25. On 7/22/25 the sheet failed to document fluid intake on all 3 shifts/for 24 hours. On 7/23/25 the sheet failed to document fluid intake on all 3 shifts/for 24 hours. On 7/24/25 Resident #5's fluid intake was 120 ml for 11:00 PM to 7:00 AM and 960 ml for 7:00 AM to 3:00 PM with no documentation recorded for 3:00 PM to 11:00 PM. On 7/25/25 Resident #5's fluid intake was 960 ml for 7:00 AM to 3:00 PM and 360 ml for 3:00 PM to 11:00 PM with no documentation recorded for 11:00 PM to 7:00 AM. On 7/26/25 Resident #5's fluid intake was 480 ml for 11:00 PM to 7:00 AM with no documentation recorded for 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. On 7/27/25 the sheet failed to document fluid intake on all 3 shifts/for 24 hours. On 7/28/25 Resident #5's fluid intake was 960 ml for 7:00 AM to 3:00 PM with no documentation recorded for 11:00 PM to 7:00 AM and 3:00 PM to 11:00 PM. On 7/29/25 Resident #5's fluid intake was 120 ml for 11:00 PM to 7:00 AM, 720 ml and 960 ml for 7:00 AM to 3:00 PM with no documentation recorded for 3:00 PM to 11:00 PM. On 7/30/25 Resident #5's fluid intake was 720 ml for 7:00 AM to 3:00 PM with no documentation recorded for 11:00 PM to 7:00 AM and 3:00 PM to 11:00 PM. On 7/31/25 Resident #5's fluid intake was 480 ml for 3:00 PM to 11:00 PM with no documentation recorded for 11:00 PM to 7:00 AM and 7:00 AM to 3:00 PM. The I/O sheets failed to tally Resident #5's intake for a 24 hour period, to ensure adequate fluid intake (however, fluid goals were not established from the Dietician's assessment on 6/3/25 and therefore there was not a quantitative measurement to assess fluid goal achievement). Interview and clinical record review with the Dietician on 8/1/25 at 11:39 AM identified fluid goals for residents could be found in the nutrition assessments. The Dietician identified the fluid goal for Resident #5 was 2,550 ml in 24 hours. Additionally, the Dietician identified he would look at resident fluid intake when doing the nutrition assessments, but he was unable to demonstrate where in the clinical record he would look to find the fluid intake for residents. The Dietician identified he also attended the Risk Meetings every Friday and that at those meetings was documentation of residents that were not meeting their fluid goals, and he would use that information when completing quarterly assessments. 2. Resident #61 had diagnoses that included heart failure, diabetes, and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was moderately cognitively impaired, required setup or clean-up (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with eating, substantial/maximal assistance with bed mobility, and was dependent for transfers.The Resident Care Plan (RCP) dated 5/1/25 identified Resident #61 was at risk for sepsis related to recurrent UTIs. Interventions included to administer antibiotics as ordered, encourage fluids, intake/output (I&O) as ordered or per policy, and watch for signs and symptoms of UTI (fever, mental status changes, increased frequency to void, burning on urination, hematuria, and pain in back or bladder region) and report to the physician/APRN.An Advanced Practice Registered Nurse (APRN) order dated 5/6/25 directed to perform a bladder scan one time a day for post-void residual, nurse may perform a straight catheterization for bladder scan results greater than 300 milliliters (ml), and please put results in the APRN book.An APRN order dated 7/30/25 directed to administer Ciprofloxacin (a broad spectrum antibiotic) 250 milligrams (mg) by mouth 1 time a day for 14 days.Interview with Nurse Aide (NA) #1 and NA #2 on 7/31/25 at 8:15 AM identified that when they documented the food and drink intake for residents in the electronic medical record (EMR) it did not ask for them to enter an amount of liquid consumed. NA #1 and NA #2 identified that they would look inside the Intake & Output (I&O) binder at the nurse's station to see which residents were on I&O's, and it they saw a resident on their assignment in the book for the date they were working, they would document the amount of I&O's for those residents.Nursing note written by Licensed Practical Nurse (LPN) #8 on 7/31/25 at 11:48 PM identified Resident #61 continued on antibiotics for a UTI and he/she was encouraged to continue with increased fluid intake.Interview with LPN #8 on 7/31/25 at 12:10 PM identified that unless there was a physician order in the EMR for I&O's, she wouldn't know which residents required I&Os. LPN #8 further identified I&O information was not on the nursing report sheets, and she didn't receive that information from the off-going nurse in report.Physician order dated 8/1/25 (original order date 9/23/24) directed to encourage fluids every shift.Interview with APRN #1 on 8/1/25 at 9:00 AM identified when she wrote in a progress note enhanced fluid intake she meant for nursing staff to encourage fluids for that resident. APRN #1 identified she would often order an additional 240 ml of fluid every shift for 3 days or sometimes 5 days to give the resident a boost in fluid intake because she didn't see consistent documentation of fluid intake by the nursing staff. APRN #1 identified when she wrote an order for additional fluids every shift she would verify the intake by talking with the nurses to see how the resident was doing with the extra fluid intake. APRN #1 identified when she wrote a progress note stating enhance fluid intake protocol maintained she would verify that it was maintained by checking blood work, through her assessments, and by speaking with the nurses. APRN #1 stated it was hard to easily see the residents' fluid intake in the EMR or clinical record because she wasn't able to definitively see a documented amount of intake. APRN #1 identified that she was implemented increased fluid intake protocol for Resident #61 for supplemental hydration to optimize bladder irrigation and reduce urinary tract bacterial colonization, her expectation was for Resident #61 to meet his/her fluid goals. Additionally, APRN #1 identified Resident #61 needed a lot of prompting for adequate fluid intake, and when Resident #61 didn't consume enough fluids it contributed to his/her urinary symptoms and could contribute to his/her development of UTIs. APRN #1 further identified she was aware that Resident #61 was complaining of abdominal pain and stating that his/her urine was hot, and that it was a frequent occurrence for Resident #61 to report those signs/symptoms which was why she would order additional fluids for Resident #61 at times.APRN #1's progress not dated 8/1/25 at 10:00 AM identified Resident #61 was seen for a follow-up evaluation for persistent dysuria and recurrent UTIs. The note identified Resident #61 reported continued dysuria despite the current antimicrobial therapy with Ciprofloxacin which had been initiated for symptomatic urinary tract infection. The note identified between April 2025 and July 2025 Resident #61 had experienced 4 documented symptomatic UTI episodes with persistent symptoms despite multiple antimicrobial regimens. The note identified Ciprofloxacin had subsequently been initiated prophylactically as a result of the treatment failures with the prior antimicrobials. The note further identified that Resident #61 continued to experience a urinary burning sensation even after implementation of the prophylactic Ciprofloxacin. Interview and clinical record review with (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietician on 8/1/25 at 11:39 AM identified fluid goals for residents could be found in the nutrition assessments. The Dietician identified the fluid goal for Resident #61 was 1,600 ml in 24 hours. Additionally, the Dietician identified he would look at resident fluid intake when doing the nutrition assessments, but he was unable to demonstrate where in the clinical record he would look to find the fluid intake for residents. The Dietician identified he also attended the Risk Meetings every Friday and that at those meetings was documentation of residents that were not meeting their fluid goals, and he would use that information when completing his quarterly assessments.Interview with NA #10 on 8/1/25 at 2:39 PM identified she would look in the I&O binder at the nurse's station to see which residents were on I&O's. NA #10 further identified that if she did not see an Intake/Output Record sheet in the binder, for the residents on her assignment, with the current date written in, then she would not fill in any intake or output information.Review of Resident #61's Intake/Output Report sheet in the I&O binder on Wing 200 identified documentation of I&Os on 7/8/25, 7/11/25, 7/12/25, 7/13/25, 7/15/25, 7/15/25, 7/20/25, and 7/21/25. On 7/8/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 120 ml, with no documentation recorded for the 7:00 AM to 3:00 PM or 3:00 PM to 11:00 PM shifts. On 7/11/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 180 ml and fluid intake on 3:00 PM to 11:00 PM was 480 ml, with no documentation recorded for the 7:00 AM to 3:00 PM shift. On 7/12/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 120 ml, with no documentation recorded for the 7:00 AM to 3:00 PM or 3:00 PM to 11:00 PM shifts. On 7/13/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 120 ml, with no documentation recorded for the 7:00 AM to 3:00 PM or 3:00 PM to 11:00 PM shifts. On 7/15/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 120 ml, with no documentation recorded for the 7:00 AM to 3:00 PM or 3:00 PM to 11:00 PM shifts. On 7/20/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 180 ml, with no documentation recorded for the 7:00 AM to 3:00 PM or 3:00 PM to 11:00 PM shifts. On 7/21/25 Resident #61's fluid intake 11:00 PM to 7:00 AM was 120 ml, with no documentation recorded for the 7:00 AM to 3:00 PM or 3:00 PM to 11:00 PM shifts. Review of the I&O binder did not identify I&O documentation for Resident #61 after 7/21/25, and additionally, did not identify that Resident #61's 24 hour intake totals were not at or near his/her fluid goal of 1600 ml in 24 hours.Nursing note by LPN #4 on 8/2/25 at 4:01 PM and 8/4/25 at 6:30 AM identified Resident #61 continued on antibiotics by mouth for a UTI.Interview, clinical record review and review of facility documentation with the Director of Nursing (DNS) and RN #5 on 8/4/25 at 2:20 PM identified I&O documentation for residents would be found in the I&O binder, but the DNS also was under the impression that the daily totals were documented in the EMR by the 3:00 PM to 11:00 PM nurse. The DNS identified Resident #61 should be on I&Os when he/she had complaints of pain and UTI symptoms, but that being on a prophylactic antibiotic due to chronic UTIs did not qualify him/her to be on I&Os. The DNS also identified that once placed on I&Os, Resident #61 would no longer require them once re-evaluated for whatever qualified him/her to need I&Os documented. DNS further identified once Resident #61 met or came close to meeting his/her daily fluid goals, his/her I&Os could be stopped. DNS identified I&Os were discussed at the weekly Risk Meetings, and the I&O portion of the meeting was provided by the Assistant Director of Nursing (ADON) who also ran the Risk Meetings. Review of the binder containing all Risk Meeting documentation reviewed at each meeting in 20205 did not identify I&O documentation showing which residents were not meeting their fluid goals, and which residents were on I&Os. DNS identified she did not attend the risk meetings, but due to the missing documentation on I&Os from the binder she would start attending the weekly risk meetings. During the interview, Regional Clinical Director, RN #5 attempted to obtain and verify I&O documentation in the EMR but was unable to print any report or find documentation related to I&Os for residents on any of the 3 units. Review of the Hydration Protocol policy directed, in part, all residents' fluid needs will be reassessed by the dietician on a quarterly basis prior to the care plan review. The policy directed I&O monitoring will be initiated when ordered by a physician or as a nursing measure for any resident with: antibiotic therapy-for duration of therapy or continued symptoms, or for a change in condition that may alter the hydration status. The policy directed nursing must complete (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and document a hydration assessment when I&O monitoring is discontinued. The policy directed all nursing personnel are responsible for recording I&Os, the nurse is responsible for ensuring a properly dated I&O record is in place, with estimated fluid needs, and for completing the subtotal I&O at the end of their shift.Review of the Intake & Output (I&O) Monitoring Policy directed, in part, I&Os will be initiated only when clinically indicated based on the results of the hydration risk screening which may be completed when clinically indicated. The policy directed if 2 or more risk factors (poor po intake, cognitive impairment impacting fluid intake, use of medications affecting fluid balance) are identified on the assessment, I&O may be initiated as a nursing measure. The policy directed that the nurse is responsible for ensuring an I&O record is initiated when indicated, reviewing I&O totals at the end of the shift, and totaling 24 hour I&Os.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, and interviews for 1 of 2 residents (Resident #84) reviewed for respiratory care, the facility failed to ensure physician orders were in place for cleaning/managing of a resident's continuous positive airway pressure (CPAP) machine (delivers constant and steady air pressure to help you breathe while you sleep). The findings include: Resident #84 had diagnoses that included quadriplegia, obstructive sleep apnea (OSA), and morbid obesity.The Nursing admission assessment dated [DATE] at 3:05 PM identified Resident #84 was cognitively intact, required assistance with eating, was dependent for bed mobility, and required the assist of 2 staff members for transfers with a mechanical lift.A physician progress note written by the Medical Director on 4/2/25 at 12:11 PM identified Resident #84 had OSA and significant hypercarbic respiratory symptoms in the past. The note identified to continue with Resident #84's current use of the CPAP machine throughout the day.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #84 was cognitively intact, used a motorized wheelchair, was dependent for eating, bed mobility, transfer, and to wheel his/her motorized wheelchair. The assessment failed to identify Resident #84 received oxygen therapy treatment or used a CPAP machine.A physician order dated 4/16/25 directed to place the CPAP machine with settings at 16 H20 every shift related to OSA.The Resident Care Plan (RCP) dated 4/21/25 identified Resident #84 required staff assistance with activities of daily living (ADLs) (basic self-care tasks performed regularly including bathing, dressing, toileting, eating, walking, transferring, managing bowel and bladder functions, and grooming). Interventions included to assist with feeding as needed, incontinent care per policy, and keep commonly used/needed articles within reach. The RCP failed to identify Resident #84 had a diagnosis of OSA and used a CPAP machine.Observation on 7/28/25 at 11:33 AM, 7/28/25 at 2:25 PM, and 7/29/25 at 10:52 AM identified Resident #84 lying supine in bed with the head of bed flat while wearing his/her CPAP. Observation and interview of Resident #84 on 7/29/25 at 12:10 PM identified Resident #84 had been at the facility since the end of March 2025 and he/she used his/her CPAP machine all day long. Observation of the CPAP machine did not identify oxygen attached to the CPAP machine. Review of the clinical record failed to identify physician orders for cleaning of Resident #84's CPAP machine, filling of the water reservoir, or for changing of the CPAP tubing.Observation on 7/30/25 at 11:56 AM identified Resident #84 lying supine in bed with the head of bed flat while wearing his/her CPAP. Subsequent to surveyor inquiry, a physician order dated 7/31/25 directed to clean the headgear for the CPAP mask every month on the first Saturday and as needed.Interview with the Director of Nursing Services (DNS) on 8/4/25 at 10:30 AM identified it was the responsibility of the admitting nurse to ensure orders were in place for the management of the CPAP machine (machine settings, donning/doffing of the mask, cleaning, filling water reservoir). The DNS could not identify the policy for the cleaning of the CPAP machine but stated it would be according to the manufacturer guidelines and that tubing would be replaced as needed by the facility oxygen company.

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Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 1 of 1 sampled resident (Resident #45) reviewed for dialysis, the facility failed to ensure accurate physician's orders were obtained for a dialysis access site. The findings include:Resident #45's diagnoses included Type 2 Diabetes Mellitus, end stage renal disease with dependence on renal dialysis. An Inter-Agency Referral form (W-10) from the hospital dated 2/26/25 indicated that Resident #45 had a double-lumen right subclavian vein hemodialysis catheter in place. Physician orders dated 2/26/25 directed staff to ?Remove dressing to Fistula on right upper chest 8 hours post dialysis unless otherwise ordered every evening shift Mon, Wed, Fri (a discrepancy with the W-10 which identified Resident #45 having a double-lumen right subclavian vein access and not a right upper chest fistula). The Resident Care Plan dated 2/27/25, identified Resident #45 had chronic kidney disease (CKD), including attending dialysis three times weekly, being at risk for bleeding, infection and septic shock, and having a right chest double lumen catheter through which Resident #45 received dialysis treatments. Interventions included contacting the dialysis center for questions about care, instructions if bleeding was observed, and observation of the resident's dialysis site as ordered, including notification to provider of any signs or symptoms of infection. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 had intact cognition and required no assistance with activities of daily living. Additionally, the MDS indicated that Resident #45 was receiving hemodialysis as part of his/her care. Physician orders dated 3/8/25 direct staff to ?Check dialysis site upon resident's return to facility every evening shift Monday, Wednesday, and Friday. A review of the Treatment Administration Record (TAR) indicated to remove dressing to the fistula on the right upper chest (Resident #45 did not have a fistula as an access site, but had a double-lumen right subclavian vein hemodialysis catheter in place) 8 hours post dialysis every Mon, Wed, Fri. An interview and observations with Resident #45 on 7/28/25 at 11:45 AM indicated all dialysis-related care was managed and provided by his/her dialysis facility. The resident's double-lumen right subclavian vein hemodialysis catheter was visible on the right side of the Resident #45's chest. An interview and clinical record review with the DNS on 8/4/25 at 1:39 PM identified that Resident #45 had a W-10 that reflected his/her right chest double-lumen right subclavian vein hemodialysis catheter access for dialysis treatment. The DNS confirmed that the clinical record reflected that physician's orders directed staff to remove the dressing from the fistula in the right upper chest eight hours post dialysis treatment. The DNS indicated that this was incorrect and that this should be changed to reflect that Resident #45 had a catheter in place versus a fistula. The DNS indicated that the dressing removal and access evaluation orders would have been entered in the EHR based on discharge orders from the hospital when the resident was admitted to the facility in February 2025. The DNS indicated that she would need to obtain corrected orders based on the access type in place. An interview with the Clinical Coordinator (CC) from Resident #45's dialysis facility on 8/4/25 at 1:57 PM indicated that Resident # 45 received dialysis treatment every Monday, Wednesday, and Friday via central venous catheter (CVC) a double-lumen right subclavian vein catheter. The CC indicated that upon admission to the dialysis facility, or placement of a CVC, all patients, including this resident, were instructed that only the dialysis staff was to touch the CVC and the CVC dressing, and that no specific communication would have been provided to the rehabilitation facility unless a problem arose with care of the access. The CC indicated that the dialysis center applies a dressing to Resident #45's access site, had not returned to dialysis treatment without a CVC applied dressing in place and also indicated that a treatment (per the TAR) to remove the dressing eight hours after treatment was inappropriate for care of this kind of access. Review of the policy Consultation for Outside Medical Appointments directed, in part, that follow-up from outside appointments should include a review of any instructions or recommendations provided by the outside healthcare provider, implement any (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	necessary care plan changes or follow-up appointments, and communicate the outcomes and recommendations to the resident, family, and relevant staff.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, review of the clinical record, and facility policy for 3 of 4 residents (Resident #42, Resident #88, Resident #89) observed for medication administration, the facility failed to ensure the medication error rate was not 5 percent (%) or greater (the error rate was 17.8%). The findings include::1.Resident #42 had diagnoses that included a central nervous system autoimmune condition, constipation, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #42 was moderately cognitively impaired, received an injection 3 out of 7 days, required substantial/maximal assistance with bed mobility and was dependent for eating and transfers. The Resident Care Plan dated 4/17/25 identified Resident #42 had a central nervous system autoimmune condition that affected his/her brain and spinal cord that resulted in loss of muscle control, vision, balance, and sensation. Interventions included to administer medications as ordered, encourage rest periods as needed, and watch for and report urinary frequency, retention, and increased constipation. A physician order dated 5/14/25 directed to administer Betaseron (interferon beta-1b) (medication used for treatment of relapsing forms of a central nervous system autoimmune condition) 0.3 milligrams (mg) via the syringe kit and inject 0.3mg subcutaneously one time a day every Monday, Wednesday, and Friday and rotate injections site. Observation of medication administration for Resident #42 by Licensed Practical Nurse (LPN) #4 and interview with LPN #4 on 7/30/25 at 9:47 AM identified LPN #4 prepared the injection, by popping the cap off a vial containing Betaseron powder and cleaned the rubber top of the vial with an alcohol wipe, she then removed the cap from a pre-filled diluent syringe and cleansed the end with an alcohol wipe and twisted the end of the syringe onto the end of the vial adapter, she then picked up the vial of Betaseron powder and attached it to the blue connector on the vial adapter. LPN #4 then approached Resident #42 with the syringe/vial assembly and cleansed Resident #42's left upper abdomen with an alcohol wipe and administered the injection subcutaneously in Resident #42's left upper quadrant of the abdomen. During the injection administration the Betaseron vial was observed to be attached to the vial adapter and positioned below the level of the syringe. After administration of the injection, LPN #4 looked at the vial beneath the syringe and said, the resident got it all, the powder is gone. The vial was observed to be 1/3 full of a cloudy liquid. LPN #4 stated that the cloudy liquid was just some left over water from the injection, and that she had questioned the same thing when she first started administering the injections. LPN #4 further stated there was always some water left over in the vial after administering the injection. Interview with LPN #4 on 7/30/25 at 11:35 AM identified she had received training on administration of the Betaseron injection from the nurses she had shadowed during her orientation when she was new to the facility. LPN #4 identified she had not received any documents, pictures, or videos to review for the administration instructions. LPN #4 further identified she had only watched her trainers administer the injection to learn the process. Interview with Pharmacy Consultant on 7/30/25 at 1:26 PM identified due to her not being present for the administration of the Betaseron injection, she could not identify if Resident #42 had received any of the Betaseron medication as it was prepared and administered by LPN #4. Pharmacy Consultant (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified that when administered routinely, receiving partial doses of the medication due to improper preparation and administration would not have any adverse effects. Pharmacy Consultant was unable to identify if Betaseron would have full effect from receiving several partial doses over the month. Interview with RN #2 on 7/31/25 at 2:35 PM identified she had not provided education on administration of the Betaseron injections to the licensed nurses in the facility because Resident #42 was already receiving the injections when she started in the staff education position and she had not been requested to perform that education with the licensed nurses. Interview with Advanced Practice Registered Nurse (APRN) #1 on 8/1/25 at 9:00 AM identified she was not aware that Resident #42 had received one or more injections of Betaseron administered incorrectly. APRN #1 identified Resident #42 had been on the medication for over a year, that receiving partial doses wouldn't really have an adverse effect, and that Resident #42 had not had any worsening of symptoms recently. APRN #1 could not identify what the benefit was for Resident #42 in receiving the medication injections when missing or partial doses were not expected to have negative effects. APRN #1 further identified she would ensure licensed nursing staff were properly administering the full dose of the medication going forward and she would then discuss with Resident #42 and his/her family on how they wanted to proceed with the medication. Review of the July 2025 Medication Administration Record (MAR) ffom 7/1/25 through 7/31/25 identified Resident #42 was administered Betaseron injections by LPN #4 a total of 8 times in July 2025 (7/2/25, 7/4/25, 7/9/25, 7/11/25, 7/14/25, 7/16/25, 7/28/25, and 7/30/25). Review of the Betaseron manufacturer package insert identified the steps for preparation of the injection are reconstituting the Betaseron, preparing the injection, and then picking an injection site and administering the injection. For reconstituting the Betaseron: remove the Betaseron vial from the plastic tray (vial holder) and take the cap off the vial; place the vial back into the vial holder and clean the top of the vial with an alcohol prep pad; open the blister pack with the vial adapter in it but do not remove the vial adapter or touch it; while keeping the vial adapter in the blister pack place the adapter on top of the vial and push down until it pierces the rubber top of the vial and snaps in place, remove the blister packaging from the vial adapter; remove the orange rubber cap from the diluent syringe and discard the cap; keeping the vial adapter attached to the vial, remove the vial from the tray; connect the syringe to the vial adapter by turning clockwise and tighten carefully; holding the syringe with the vial of Betaseron underneath the syringe slowly press the plunger of the syringe to inject the diluent into the Betaseron vial; gently swirl the syringe/vial assembly until the white powder cake of Betaseron is dissolved; after the cake is dissolved look closely to ensure the solution is clear and colorless without particles. For preparing the injection: push the plunger in and hold it there, then turn the syringe/vial assembly so the vial is on top (the syringe is horizontal); slowly pull back on the syringe plunger until all of the solution in the Betaseron vial is inside the syringe; turn the syringe/vial assembly so that the needle end is pointing up and remove any air bubbles by tapping the outer wall of the syringe with your fingers, then slowly press the plunger until it is at the 1 milliliter (ml) mark on the syringe; remove the vial adapter and the vial from the syringe by twisting the vial adapter which will remove the vial adapter and vial from the syringe but will leave the needle on the syringe; then choose an injection site and administer the injection. 2.Resident #88's diagnoses included unspecified dementia, alcohol abuse with withdrawal, and gastro-esophageal reflux disease (GERD) with esophagitis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #88 was moderately (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively impaired and was independent for self-care and dependent on staff for chair/bed-to-chair transfers. The Resident Care Plan dated 7/11/25 identified Resident #88 had alcohol use/abuse with interventions that included dietary consults as needed to ensure adequate nutrition and hydration and to provide medications as ordered. A physician's order dated 5/1/25 directed to administer B12 active oral chewable tablet (Methylcobalamin) by mouth in the morning for vitamin supplement related to alcohol abuse with withdrawal. A physician's order dated 6/25/25 directed to administer Pantoprazole Sodium Oral Tablet Delayed Release 40 milligrams (mg), 1 tablet by mouth one time a day for GERD. Observation of medication administration on 7/30/25 at 8:10 AM with Licensed Practical Nurse (LPN) #5 identified she had prepared and dispensed all ordered and scheduled oral medications for 8:00 AM for Resident #25 with the exception of B12 (Methylcobalamin) and Pantoprazole 40 mg which were unavailable in the medication cart. LPN #5 indicated that she documented in the residents' chart that the medication was unavailable and ordered the medication through the pharmacy. Review of the Medication Administration Record (MAR) for 7/30/25 for Resident #88 identified B12 (Methylcobalamin) and Pantoprazole 40 mg were documented as medication unavailable for 8:00 AM. Review of Resident #88's clinical record on 7/31/25 at 9:25 AM failed to identify documentation and notification to the provider and pharmacy for the medications that were not administered (Please refer to F 580). Interview with the Registered Nurse Supervisor (RN #3) on 7/31/25 at 10:15 AM identified that she was the nurse supervisor on 7/30/25 for the 7:00 AM to 3:00 PM shift. RN #3 indicated that LPN #5 was responsible for administering all Resident #88's medications as ordered and that if medications were not available in the medication cart at the time of administration, LPN #5 should have notified her. RN #3 indicated that per policy, if she was made aware she would have checked the stock medication in the medication rooms to see if they were available. If not available, LPN #5 or herself would notify the pharmacy to order the medication and notify the provider to obtain orders if okay for late administration. Additionally, RN #3 indicated that the omission and notifications should be documented in the resident's electronic health record. Interview with LPN #5 on 7/31/25 at 10:55 AM identified that if a medication was unavailable during administration, it should be documented and the nurse supervisor, pharmacy and provider should be notified. LPN #5 indicated that she did not notify the supervisor or provider but placed an order for the medication to the pharmacy through the electronic health record. LPN #5 indicated that she forgot to notify nurse supervisor and provider because she became busy attending to other residents. Additionally, the interview identified that LPN #5 did not communicate that the medications were not administered and unavailable to the oncoming shift nurse. Interview with the Director of Nursing Services (DNS) on 7/31/25 at 2:19 PM identified that if a medication was unavailable during medication administration, that the nurse should go check the overflow medications and if not available, notify the nurse supervisor, provider and pharmacy. The DNS indicated that it was the overall responsibility of the nurse supervisor to ensure the follow-up for (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications that are unavailable and that it is the responsibility of the administering nurse to notify the nurse supervisor. 3.Resident #89's diagnoses included gastro-espophageal reflux disease (GERD), type 2 diabetes mellitus, muscle weakness and unsteadiness on feet with a history of falling. Physician's orders dated 7/1/25 directed to administer Sucralfate 1 gram tablet, give 1 tablet by mouth four times a day for GERD, give before meals and at bedtime and Cilostazol tablet, give 50 milligrams (mg) (a medication to treat poor blood flow to the legs) by mouth two times a day for claudication pain, give on an empty stomach or 2 hours after last meal. The annual Minimum Data Set assessment dated [DATE] identified Resident #89 was severely cognitively impaired and required extensive assistance with bed mobility, toileting and transfers. The Resident Care Plan dated 7/24/25 identified a moderate nutritional risk and constipation due to decreased mobility and use or narcotic analgesia. Interventions included administering diet and medications as ordered. Observation of medication administration on 7/30/25 at 1:10 PM with Licensed Practical Nurse (LPN) #2 identified she had poured Sucralfate 1 gram tablet, Cilostazol 50 mg and Simethicone 80 mg into a medication cup, and administered to Resident #89 after checking with Resident #89's photo ID and conversing with him/her in Spanish. Additionally, Resident #89 was seated in a bedside chair and the empty/dirty dishes from his/her lunch meal were observed on the bedside tray table. LPN #2 and Resident #89 confirmed the resident had just finished eating his/her lunch prior to administration of medications to the resident, LPN #2 confirmed there were 3 tablets in the medication cup as follows: Sucralfate 1 gram, 1 tablet, Cilostazol 50mg, 1 tablet and Simethicone 80mg, 1 tablet. Medication reconciliation for Resident #89 identified LPN #2 failed to administer Sucralfate 1 gram by mouth before meals and Cilostazol 50 mg by mouth on an empty stomach during the medication administration observation on 7/30/25 at 1:10 PM. Review of the Medication Administration Record (MAR) for 7/30/25 identified Sucralfate 1 gram at 12:00 PM and Cilostazol 50mg at 2:00 PM were signed as administered by LPN #2. Interview and review of the clinical record with LPN #2 on 7/30/25 at 1:30 PM identified that she had administered the Sucralfate 1 gram and Cilostazol 50 mg directly after Resident #89 had finished eating his/her lunch meal and had made a mistake. LPN #2 indicated she should have administered both medications to Resident #89 before his/her meal and that she had failed to follow the directions in the physician's orders. LPN #2 identified she tried to group all the resident's afternoon medications together and administer them at one time and should not have done that. LPN #2 further indicated she would make the nursing supervisor and the prescriber aware of her medication error. Interview and review of the clinical record with the DNS on 7/31/25 at 11:39 AM identified Resident #89's Sucralfate order indicated administration before meals and the Cilostazol order indicated administration on an empty stomach. The DNS indicated both medications should have been administered to Resident #89 as directed in the physician's orders and it was the responsibility of LPN #2 to follow the physician's orders as a standard of practice. The DNS further identified Resident #89 should not have received the Sucralfate and Cilostazol right after eating lunch and that she would need to provide further education to LPN #2 regarding administering medications according to the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's order. Interview with the pharmacy consultant on 8/5/25 at 2:10 PM identified the medication Sucralfate helped protect the stomach from ulcers and administering the medication with food would disrupt the process and cause the medication to not work as well. The pharmacy consultant indicated the medication Cilostazol was prescribed to increase blood flow to the legs and improve pain and failing to administer the medication on an empty stomach would affect its absorption and effectiveness. The pharmacy consultant identified it was the responsibility of the nurse administering medication to follow the physician's orders for time of administration and other directives and she would let the DNS know to further educate the nursing staff. Review of the facility policy, Medication Administration, undated, directed all medications shall be administered safely and accurately in accordance with physician orders, facility protocols, and applicable state and federal regulations. The policy further directed staff must demonstrate competency in medication administration through regular skills assessments. The medication error rate was 17.86% based on the medication administration observation task.

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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 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. Based on observations, facility documentation, facility policy and interviews, the facility failed to clean the only facility ice machine according to manufacturer guidelines. The findings include: Observation of the only facility ice machine on 8/1/25 at 3:21 PM identified diffusely scattered spots of a black substance inside the ice machine on the surface of a white plastic piece that extended from one side of the ice machine to the other side of the ice machine. The ice machine was filled with ice which prevented visualization of additional surfaces within the ice machine. A yellow service record on the outside of the ice machine indicated that the ice machine and air filters were chemically cleaned by the facility's refrigeration company on 11/12/24 and the water filter was changed on 12/2/24. No additional entries were made on this record after 12/2/24. Interview with Refrigeration Company Dispatcher on 8/1/25 at 3:27 PM identified the company had last been out to the facility to clean the ice machine on 11/11/24, that there was only 1 ice machine that was serviced by their company, and that the corporate officials for the facility had cancelled the maintenance contract for the ice machine earlier this year.Interview with Corporate Registered Nurse (RN) #6 on 8/1/25 at 3:35 PM identified the ice machine was cleaned and/or serviced by the either the refrigeration company or the foodservice company.Interview with RN #6 and the Administrator on 8/1/25 at 3:40 PM identified the Administrator was not certain who cleaned/serviced the ice machine but she thought that the facility maintenance/housekeeping department was cleaning it. The Administrator called the Corporate Maintenance Director to ask if the facility was cleaning the ice machine and left a message to call her back.Interview with RN #6 on 8/1/25 at 3:54 PM identified that the refrigeration company had been called to come out and perform a 1 time cleaning service to the ice machine, and that him and Administrator were still waiting on a return call from the Corporate Maintenance Director.Observation on 8/4/25 at 8:00 AM identified a sign on the lid of the ice machine that indicated not to use the ice.Interview with the Director of Maintenance on 8/4/25 at 8:10 AM identified that his staff had not been cleaning the ice machine, or checking the machine for cleanliness, and that it was his understanding that the ice machine was cleaned by the refrigeration company. The Director of Maintenance identified that the refrigeration company had been called and were due to come out later this day to clean the ice machine, and until then the nursing department said no one was supposed to use the ice machine until after it was cleaned. He further identified that the dietary department had purchased ice and it was available in the kitchen for the facility to use until the ice machine was cleaned.Interview with Administrator on 8/4/25 at 10:08 AM identified she had received a return call from the Corporate Maintenance Director, and that the facility was supposed to have called the refrigeration company when the ice machine was due to be cleaned. Administrator further identified that Corporate officials had emailed the Administrators of each facility to inform them that the refrigeration company needed to be called as needed for cleaning and/or servicing of the ice machine. The Administrator was not aware of the policy schedule for the cleaning of the ice machine.Interview with the Regional Maintenance Director on 8/4/25 at 10:20 AM identified that the facility followed the manufacturer guidelines for the cleaning of the ice machine, and that the guidelines directed to clean the ice machine at least every 6 months. The Regional Maintenance Director identified that the quarterly automatic servicing contract for the ice machine had been discontinued, but that the cleaning schedule every 6 months should still be in place and that the facility just needed to call to have the refrigeration company come out and clean the ice machine. He was unable to identify why this had not happened.Review of an email sent by [NAME] President of Operations to the refrigeration company on 2/6/25 at 3:07 PM identified that the refrigeration company was requested to remove the contracts in place for preventative maintenance and that the facilities would reach out as needed for services related to preventative work. The email further identified that much of the ice machine equipment had manufacturer recommendations for yearly (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning, and that if the facilities were calling to have the ice machines cleaned more frequently than once a year, that the Corporate officials would like a call from the refrigeration company in advance of the ice machine cleaning visit to the facility. Review of the manufacturer guidelines manual for cleaning of the ice machine identified the facility was responsible for maintaining the ice machine in accordance with the instructions in the manual. The manual directed to descale and sanitize the ice machine every 6 months for efficient operation. The manual directed detailed descaling/sanitizing must be performed a minimum of once every 6 months and that a remedial cleaning procedure to descale all components in the water flow path is used between the bi-yearly detailed descaling and sanitizing procedure.Although requested, a facility policy for cleaning of the ice machine was not provided.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and review of the facility Quality Assurance and Performance Improvement (QAPI), the facility failed to recognize and put measures in place to ensure neurological assessments were completed for a resident with a significant amount of falls (Resident #56). The findings include: Resident # 56's diagnosis included Parkinson's disease, peripheral vascular disease, and hypertension.Resident #56 was admitted to the facility on [DATE].A nursing admission assessment (the admission Minimum Data Set assessment had not yet been completed) dated 1/29/25 identified Resident #56 was severely cognitively impaired and required assistance of 2 for bathing, transferring and personal care.The Resident Care Plan (RCP) dated 2/2/25 identified Resident #56 was at risk for falls due to multiple risk factors with intervention to toilet Resident #56 prior to dinner, encourage Resident #56 to ask and wait for staff assistance for transfers and/or toileting.a. A facility Accident and Incident report dated 2/2/25 at 5:00 PM identified Resident #56 was observed sitting on the floor in the lounge. No complaints of pain/discomfort or injuries noted and noted it was an unwitnessed fall. A nursing note dated 2/2/25 at 5:50 PM identified Resident #56 was sitting on the floor in the lounge and had no visible injuries. Also identified neurological assessments were initiated per the facility protocols.On 8/4/25 at 12:00 PM, interview and review of the clinical record with the DNS failed to identify Neurological assessments were completed, despite the nursing note dated 2/2/25 at 5:50 PM indicating neurological assessments were initiated per the facility protocols.b. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 was severely cognitively impaired and required supervision with eating. Also identified Resident #56 required maximal assistance for toileting, bathing, personal hygiene, and transfers from bed to chair. Additionally, the MDS indicated Resident #56 had 2 or more falls since admission.A facility Accident and Incident report dated 3/4/25 at 2:15 PM identified Resident #56 had an unwitnessed fall. The report identified Resident #56 was observed lying on his/her right side in another resident's room. No injuries were noted.A nursing note dated 3/4/25 at 3:40 PM identified Resident #56 fell and was observed laying on the floor. Also, identifying the responsible party refused to have the resident sent out to the hospital to be evaluated for a neurological assessment.Interview and review of the Neurological Assessment flow sheet on 8/4/25 at 12:00 PM with the DNS identified 17 of 21 neurological assessments were not completed.c. A facility Accident and Incident report dated 3/6/25 at 6:50 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 was lying on the floor on his/her left side across from the nurse's desk and no injury was noted.A nursing note dated 3/6/25 at 8:53 PM identified Resident #56 was found, lying on his/her left side with no complaints of pain or discomfort. Also, identifying that neurological assessment should be monitored by the facilities protocol.Interview and review of the Neurological Assessment flow sheet on 8/4/25 at 12:00 PM with the DNS identified 16 of 21 neurological assessment were not completed. d. A facility Accident and Incident report dated 4/4/25 at 6:00 PM identified Resident #56 had a fall when he/she stood up and Resident #56 hit his/her head on the wall. Additionally, the report identified Resident #56's sustained a 3 centimeter contusion to his/her left upper forehead.A nursing note dated 4/4/25 at 8:11 PM identified Resident #56 had an unwitnessed fall. Additionally, the nursing note identified Resident #56 was seated in the hallway, eating dinner, got up quickly and fell forward, hitting his/her upper left forehead area sustaining a 3-centimeter laceration to the left side of his/her forehead. Also, identifying neurological status was observed. The family was notified and Resident #56 was sent to the emergency room.A nursing note dated 4/5/25 dated at 5:12 AM identified Resident #56 returned from the hospital at 1:25 AM. Neuros to be assessed and report any changes.On 8/4/25 at 12:00 PM, interview and review of the clinical record with the DNS failed to identify Neurological assessments were completed prior to or returning from the hospital. e. A facility Accident and Incident report dated (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	4/10/25 at 9:00 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 was found on his/her knees, by the bed. A nursing note dated 4/10/25 at 11:38 PM identified Resident #56 fell at 9:00 PM and was found on his/her floor mat by the bedside. Also, identifying Resident #56 was confused, forgetful, restless, refused vital checks, fighting anyone who came in contact with him/her, the Advanced Practice Registered Nurse was notified and Resident #56 was sent to the emergency room.A nursing note dated 4/11/25 at 1:39 AM identified Resident #56 returned to the facility. Also, identified Resident #56 had a small, raised area to the right side of his/her head.A copy of the Neurological Check flow sheet was provided which noted neurological assessments were not completed with a handwritten note across the top of the form identifying resident refused Neuro checks. Interview and review of the Neurological Check flow sheet with the DNS on 8/4/25 at 12:00 PM identified if a resident refused any neurological assessments, an attempt should be made to continue to try to obtain the assessments, and writing on the top of the form resident refused was not acceptable. f. A facility Accident and Incident report dated 4/12/25 at 4:30 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 was sitting on the floor against the wall in the hallway, no injury was noted.A nursing note dated 4/12/25 at 5:11 PM identified Resident #56 had a fall with no changes in his/her neurological or cardiovascular status. Interview and review of the Neurological Assessment flow sheet on 8/4/25 at 12:00 PM with the DNS identified 9 of 21 neurological assessments were not completed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 as severely cognitively impaired and was independent for eating. Also, identifying Resident #56 was dependent on oral hygiene, showering, and dressing. Further, identifying Resident #56 required moderate assistance for transfers. Additionally, the MDS identified Resident #56 had 1 fall with no evidence of injuries.g. A facility Accident and Incident report dated 6/9/25 at 6:55 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 bump to the back of head, in the hallway.A nursing note dated 6/9/25 at 9:21 PM identified Resident #56 was seen at 6:55 PM with his/her back against the wall in a seated position. Also, identifying Resident #56 had some redness noted on the left side of the head along with a raised area to the back of the head. Further, identifying Resident #56 was sent to the emergency room for evaluation.A nursing note dated 6/10/25 at 3:18 AM (approximately 5.5 hours after the fall) identified Resident #56 returned from the emergency room at 2:50 AM with a hematoma to the back of his/her head.Interview and review of the Neurological Check flow sheet with the DNS on 8/4/25 at 12:00 PM identified neurological assessments were initiated on 6/9/25 at 6:55 PM. Also, neurological assessments were not restarted once Resident #56 returned from the hospital on 6/10/25 at 2:50 AM (Resident #56 would have required every 4 hour neurological assessments at that time). Additionally, the DNS noted when a resident returns from the hospital the neurological assessment should be resumed. Review of the Neurological Checks policy identified neurological checks will be instituted as a nursing measure following a head injury. A resident that experiences an unwitnessed fall and was unable to accurately verbalize if she/he hit their head or experienced any type of head injury will have neurological checks instituted. Also, identifying a neurological check flow sheet would be instituted by the nurse. The checks will be completed as follows:A. every 15 minutes for the first hour thenB. Every hour for 4 hours thenC. Every 4 hours for the next 24 hours then,D. Every shift for 48 hours after that.On 8/4/25 at 3:49 PM, interview with the Director of Nurses identified that the failure to complete multiple neurological assessments on a resident with multiple unwitnessed falls had not been identified/reviewed during QAPI meetings so that measures could be initiated to ensure neurological assessments were completed.

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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** Based on observation, review of facility policy and interviews for 5 resident private bathrooms and 4 resident shared bathrooms on 3 of 3 nursing units, the facility failed to ensure personal care items were properly labeled, covered, and stored according to facility policy. The findings included: Based on observation, review of facility policy and interviews for 5 resident private bathrooms and 4 resident shared bathrooms on 3 of 3 nursing units, the facility failed to ensure personal care items were properly labeled, covered, and stored according to facility policy. The findings included: Observation on 7/28/25 at 11:00 AM and observation and interview with the Infection Prevention (IP) Registered Nurse (RN) #2 on 7/30/25 at 11:49 AM identified the following on Unit 100: room [ROOM NUMBER]'s private bathroom contained one bedpan that was unlabeled, uncovered and located on the bathroom floor next to the toilet. room [ROOM NUMBER]'s private bathroom contained one bedpan that was unlabeled, uncovered and located on top of the toilet. room [ROOM NUMBER]'s private bathroom contained one bedpan that was unlabeled, uncovered and located on the bathroom floor. room [ROOM NUMBER]'s private bathroom contained one bedpan that was unlabeled, uncovered and located on the bathroom floor. room [ROOM NUMBER]'s shared bathroom contained one bedpan that was unlabeled, uncovered and located at the back of the toilet Observation on 7/28/25 at 11:15 AM on Unit 300 identified the following: room [ROOM NUMBER]'s shared bathroom contained one bedpan that was unlabeled, uncovered and located on the floor to the right of the toilet and two basins that were unlabeled, uncovered and located to the left of the toilet. Observation on 7/28/25 at 11:25 AM and observation and interview with the Infection Prevention (IP) Registered Nurse (RN) #2 on 7/30/25 at 11:49 AM identified the following on Unit 200: room [ROOM NUMBER]'s private bathroom contained one wash basin that was unlabeled, uncovered and located on the bathroom floor behind the toilet. room [ROOM NUMBER]'s shared bathroom contained one wash basin that was unlabeled, uncovered and located on top of the toilet. room [ROOM NUMBER]'s shared bathroom contained one urinal hanging next to toilet that was unbagged and unlabeled, one wash basin on the floor unbagged and labeled with the name of a resident that was not present in either room. Observation and interview with the Infection Prevention (IP) Registered Nurse (RN) #2 on 7/30/25 at 11:49 AM identified the following:room [ROOM NUMBER]'s shared bathroom contained one bedpan that was unlabeled, uncovered and located on the floor to the right of the toilet and two basins that were unlabeled, uncovered and located to top of the back of the toilet. RN #2 identified it was facility policy to have all bedpans, basins, urinals, and oxygen/nebulizer masks labeled and covered. RN #2 indicated that it was the Nurse Aid's responsibility to follow the policy and could not identify why it was not being followed. Interview and observation with the Nurse Aid (NA) #5 on 8/1/25 at 11:51 AM identified that in room [ROOM NUMBER]'s shared bathroom there was one urinal hanging next to the toilet that was unlabeled and uncovered, one bedpan located on top of the back of the toilet was unlabeled and uncovered, and two basins located on the floor were unlabeled and uncovered. NA #5 indicated that all bedpans, basins, and urinals should be labeled and covered according to facility policy. NA#5 was unable to identify why the policy was not followed and who was responsible for ensuring the personal care items were stored per policy.Interview with the Director of Nursing Services (DNS) on 8/1/25 at 12:05 PM failed to identify what the facility policy was for resident bedpans, basins, and urinals. Review of the facility policy, Bedpan giving and removing, undated, identified that bedpans are to be stored in resident's bedside dresser or store labeled bedpan in plastic bag in bathroom, ensuring not on the floor.

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F 0578 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 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** Based on review of the clinical record, facility policy and interviews for 2 of 24 residents (Resident #27 and Resident #45) reviewed for advance directives (a written statement of a resident's wishes regarding medical treatment), the facility failed to obtain a physician's order for advance directives for Resident #27 and failed to ensure advanced directives were discussed and necessary documentation completed regarding advanced directives for Resident #45. The findings include:1.Resident #27 had diagnoses that included dementia, anxiety, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 was severely cognitively impaired and independent with eating, transfers, and ambulation. The Resident Care Plan (RCP) dated 4/21/25 identified Resident #27 required staff assistance with activities of daily living. Interventions included advanced directives per physician orders. A Medical Interventions Form (advance directives) signed by Resident #27's responsible party on 6/2/25 directed Resident #27's choice for the administration of life support systems was do not resuscitate (DNR) and do not intubate (DNI). The form further identified Resident #27 directed not to administer artificial means of nutrition including tube feedings and total parenteral nutrition (TPN), and directed to administer intravenous fluids and hospitalization. Review of the clinical record failed to identify a physician's order for the advance directives identified by the Medical Interventions Form signed 6/2/25. Interview with Licensed Practical Nurse (LPN) #4 on 7/30/25 at 1:45 PM identified if she found a resident who had stopped breathing, she would verify their code status by looking in the electronic medical record (EMR) for the advance directives order located in the banner beneath the resident's name and picture because that was the most accessible place to look. Interview with the Director of Nursing Services (DNS) on 7/31/25 at 3:10 PM identified that the nursing supervisor was responsible for ensuring the advance directives were reviewed and a physician order obtained upon a resident's admission/readmission to the facility. The DNS identified that when Resident #27 was readmitted from the hospital on 7/15/25, the nursing supervisor should have checked the Medical Interventions Form and then obtained a physician's order for advanced directives. The DNS further identified that when Resident #27's previous physician orders were discontinued from the EMR upon his/her readmission from the hospital on 7/15/25 and the new physician orders were put into the EMR, the advance directives order must have been missed. 2.Resident #45 was re-admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus, heart failure and hyperlipidemia. A hospital Discharge summary dated [DATE] indicated Resident #45's code status was full code. A face sheet located in the facilities clinical record identified Resident #45 was responsible for him/herself, despite a nursing assessment dated [DATE] which identified Resident #45 was cognitively impaired and directed full code status. A medical interventions consent form (a form indicating resident preferences for cardiopulmonary (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resuscitation, the use of life support systems, and methods of artificial provision of nutrition and hydration), which was not included in the clinical record, but available upon surveyor inquiry and dated 7/19/25, was incomplete and included a staff signature but did not include a resident/responsible party signature or physician's signature. A nursing note, dated 7/19/25, indicated Resident #45 was admitted from the hospital, alert and oriented to person and place with forgetfulness. The nursing note also indicated that the resident signed a do-not-resuscitate form; however, this paperwork was not located in either the electronic or paper record during reviews on 7/29/25 and 7/31/25. This paperwork was also not provided when requested on 8/4/25. An Advanced Practice Registered Nurse (APRN) progress note dated 7/20/25 indicated Resident #45 had code status of full code, was lethargic but aroused by verbal stimuli, was able to converse despite lethargy with slurred speech at times, was able to follow simple commands and was verbally aggressive on brief periods of alertness, while cooperative. There was no indication of an advance directive discussion in this note. The Resident Care Plan, dated 7/21/25, identified a problem with Activities of Daily Living with interventions that included advanced directives per physician (MD) orders. A late entry physician's admission note dated 7/21/25 indicated that Resident #45 was alert and oriented to person, place and time, that his/her thought content was normal, and that his/her judgement was normal, but failed to reflect discussion regarding advanced directives. An APRN progress note dated 7/21/25 indicated that Resident #45 had a code status of full code and was lethargic and able to converse and follow simple commands. The note also indicated that the resident fell asleep easily and slurred his/her words at times, but failed to reflect discussion regarding advanced directives Nursing notes dated 7/22/25 at 00:03 AM and 7/24/25 at 12:14 AM indicated that Resident #45 was alert and oriented to person and place with short-term memory impairments and impaired decision-making skills, including usually understanding but at times missing the intent of messaging. APRN progress notes from 7/24/ 25, 7/25/25, 7/26/25, 7/28/25, 7/29/25, 7/31/25 and 7/31/25 indicated that Resident #45 was a full code status but failed to reflect discussion regarding advanced directives. Observation on 7/29/25 at 10:38 AM of Resident #101's paper medical record indicated that he/she did not have advanced directives in the paper medical record. The resident was indicated as a full code per the electronic health record (EHR). The clinical record failed to reflect a provider order in either paper or electronic medical records. An interview with Resident #45 on 7/30/25 at 12:50 PM indicated that he/she did not recall his/her admission, including a discussion about advanced directive choices. He/she also indicated that he/she does not recall a discussion about this topic at any time since admission. A Brief Interview for Mental Status (BIMS) was not documented in the electronic record at that time. Resident #45 was observed to be intermittently alert and oriented to person, place, and time. An interview and clinical record review with LPN #5 on 7/30/25 at 12:56 PM indicated that he/she (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was unsure where to look for code status in the event of an emergency, including what to follow if there was a difference between the EHR and paper record. He/she indicated that he/she would look in the EHR, then the paper chart, and then check with the supervisor if there was a variance or lack of information. Review of the clinical record indicated that Resident #45's status was full code in the EHR and that clinical record failed to reflect documentation of a signed acknowledgement of this option in the paper record. Observation on 7/30/25 at 1:00 PM of Resident #101's paper medical record indicated that he/she did not have advanced directives form in the paper medical record. The resident was indicated as a full code per the EHR. The clinical record failed to reflect a provider order in either paper or electronic medical records. Observation on 07/31/2025 9:30 AM of Resident #101's paper medical record indicated that he/she did not have advanced directives in the paper medical record. The resident was indicated as a full code per the EHR. The clinical record failed to reflect a provider order in either paper or electronic medical records. An interview with the facility Social Worker on 7/31/25 at 10:17 AM indicated that upon Resident #101's admission, she was concerned about his/her ability to make decisions for himself/herself. However, he/she was deemed to be his/her decision maker, and he/she remains his/her decision maker to date. The social worker indicated that nursing handles discussions with residents about advanced directives. An APRN progress note dated 8/2/25 indicated that Resident #45 was a full code status and showed marked improvement in mental status and orientation compared to the initial presentation. There was no documentation of advance directive discussion in this note. An interview with the Director of Nursing Services (DNS) on 8/4/25 at 8:15 AM indicated that nursing was responsible for discussing advanced directives with new residents on admission. The DNS indicated that when a resident was unable or unwilling to discuss advanced directives, family was contacted for determination of advanced directives. Additionally, the DNS indicated that in the absence of contact with family members, the default determination was for a resident was indicated as a full code until otherwise discussed and documented with the resident or family. A review of the policy, Advance Directives, directed the following: 'Licensed nursing staff and/or resident's attending physician will review advance directives with the capable resident or the appropriate decision maker(s) and identified the form would be signed and dated by the person who reviewed the advance directive with the resident or decision maker, and a physician's order would be obtained. If the resident or substitute decision maker(s) does not execute an advance directive the resident will be a full code until a decision is made by the resident or substitute decision maker(s).' Additionally, the procedure, indicated within the facility policy, was to document choices within the resident care plan and review advance directives on a quarterly or as-needed basis when changes occurred.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, review of the clinical record, facility documentation, and facility policy for 1 of 4 residents (Resident #88) reviewed for medication administration, the facility failed to notify the provider of medication omissions. The findings include:Resident #88's diagnoses included unspecified dementia, alcohol abuse with withdrawal, and Gastro-Esophageal Reflux Disease (GERD) with esophagitis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #88 was moderately cognitively impaired, was independent for self-care and dependent on staff for chair/bed-to-chair transfers.The Resident Care Plan dated 7/11/25 identified Resident #88 had alcohol use/abuse. Interventions included dietary consultations as needed to ensure adequate nutrition/ hydration and to provide medications as ordered.A physician's order dated 5/1/25 directed to administer B12 active oral chewable tablet (Methylcobalamin) by mouth in the morning for vitamin supplement related to alcohol abuse with withdrawal.A physician's order dated 6/25/25 directed to administer Pantoprazole Sodium Oral Tablet Delayed Release 40 milligrams (mg), 1 tablet by mouth one time a day for GERD).Observation of medication administration on 7/30/25 at 8:10 AM with Licensed Practical Nurse (LPN) #5 identified she had prepared and dispensed all ordered and scheduled oral medications for 8:00 AM for Resident #88 except for B12 and Pantoprazole 40 mg which were unavailable in the medication cart. LPN #5 indicated that she documented in the residents' chart that the medications were unavailable and ordered the medication through the pharmacy.Review of the Medication Administration Record (MAR) for 7/30/25 identified B12 and Pantoprazole 40mg were documented as medication unavailable for 8:00 AM (see F 759).Review of Resident #88's clinical record on 7/31/25 at 9:25 AM failed to identify documentation and notification to the provider for the medications that were not administered. Interview with the Registered Nurse Supervisor (RN) #3 on 7/31/25 at 10:15 AM identified that she was the nurse supervisor on 7/30/25 for the 7:00 AM to 3:00 PM shift. RN #3 indicated that LPN #5 was responsible for administering all Resident #88's medications as ordered and if medications were not available in the medication cart at time of administration, that LPN #5 should have notified her. RN #3 indicated that per policy, if she was made aware she would have checked the stock medication in the medication rooms to see if they were available. If not available, LPN #5 or herself would notify the pharmacy to order the medication and notify the provider to obtain orders if approved for late administration. Additionally, RN #3 indicated that the omission and notifications should be documented in the resident's electronic health record.Interview with LPN #5 on 7/31/25 at 10:55 AM identified that if a medication was unavailable during administration, it should be documented and the nurse supervisor, pharmacy and provider should be notified. LPN #5 indicated that she did not notify the supervisor or provider but placed an order for the medication to the pharmacy through the electronic health record. LPN #5 indicated that she forgot to notify the nurse supervisor and provider because she became busy attending to other residents. Additionally, the interview identified that LPN #5 did not communicate that the medications were not administered and unavailable to the oncoming shift nurse.Interview with the Director of Nursing Services (DNS) on 7/31/25 at 2:19 PM identified that if a medication was unavailable during medication administration, that the nurse should go check the overflow medications and if not available, notify the nurse supervisor, provider and pharmacy. The DNS indicated that it was the overall responsibility of the nurse supervisor to ensure that notifications for medications that were unavailable were documented and that was the responsibility of the administering nurse to notify the nurse supervisor.Attempts to contact the Medical Director/physician were unsuccessful.Review of the facility policy, Medication Administration, undated, directed that if medication is not available at the time of administration that staff are to notify the physician immediately and request guidance or an alternative order, inform resident or their responsible party about the situation, check with the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	pharmacy or alternative suppliers to expedite delivery of the medication, and to document all actions taken in the resident's medical record and notify the supervisor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 2 residents (Resident #84) reviewed for position/mobility, the facility failed to formulate a baseline care plan (BCP) that addressed all required areas, failed to document a timely completion of the BCP meeting, failed to document the resident/resident representative participated in the BCP and that a BCP summary was provided to the resident/resident representative. The findings include: Resident #84 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, obstructive sleep apnea, and morbid obesity.The Nursing admission assessment dated [DATE] at 3:05 PM identified Resident #84 was cognitively intact, required assistance with eating, was dependent for bed mobility, and required the assistance of 2 staff members for transfers with a mechanical lift.a. Review of a handwritten BCP dated 3/31/25 identified Resident #84 was alert and was admitted for long-term care with a primary goal of remaining long term in the facility but failed to include individualized care needs (did not include dietary needs, required a special call bell to ring for assistance due to the inability to move his/her extremities, was morbidly obese, required the assistance of 2-3 staff members for bed mobility, transfers, and incontinent care, was on anticoagulant/ opioid/psychotropic medications). Additionally, the BCP failed to identify a signature and date that the BCP was discontinued due to completion of the comprehensive resident care plan (RCP) or any updates to the BCP prior to completion of the comprehensive RCP.b. Review of the clinical record identified a 72 Hour Meeting/Discharge Planning Meeting assessment by Registered Nurse (RN) #11 and dated 4/7/25 at 1:16 PM that was completed 7 days after Resident #84's admission which was late (greater than 72 hours after admission on [DATE]). Additionally, the assessment was not fully completed. The assessment identified 26 out of 35 questions within the assessment were not completed. The assessment failed to identify interdisciplinary participation for this assessment and failed to identify the names of social services or rehabilitation services staff who participated in the meeting. c. Review of a handwritten BCP dated 3/31/25 failed to identify a signature from the resident and/or responsible party of review of the BCP and receipt of the BCP summary. Interview with RN #8 and RN #9 on 8/4/25 at 12:05 PM identified the BCP meetings were called 72 hour meetings at the facility. RN #8 identified a BCP was completed on admission and would go into the resident's hard chart (a paper medical record). RN #8 and RN #9 were unable to identify documentation of completion of a 72 hour meeting within the required 72 hour timeframe. RN #8 provided a copy of the completed handwritten BCP from Resident #84's hard chart.Interview with Licensed Practical Nurse (LPN) #6 on 8/4/25 at 12:30 PM identified the 72 hour care plan meetings were completed within the first 72 hours after a resident's admission. LPN #6 identified the care plan in the electronic medical record (EMR) was referred to during the meeting and documentation of the meeting was completed in the assessments section of the EMR and was called 72 Hour Meeting/Discharge Planning Meeting. LPN #6 identified nursing would complete their piece of the assessment, rehabilitation services (therapy) would complete their piece, and social services would complete their piece. LPN #6 identified the meeting would be completed with the resident unless they were severely cognitively impaired, and if the resident was unable to participate the responsible party would be called. LPN #6 identified that the 72 hour meeting should be completed within 72 hours of the resident's admission. LPN #6 further identified RN #11 had completed her piece of the 72 Hour Meeting/Discharge Planning Meeting assessment on 4/7/25, but that she did not see documentation from therapy or social services, and LPN #6 indicated the assessment was entered late by RN #11.Review of the Care Planning policy directed, in part, upon admission, a baseline care plan should be established to guide caregivers until a full care plan is developed. The policy directed that a comprehensive care plan will be developed no later than 7 days after the completion of the admission Minimum Data Set (MDS).

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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** Based on clinical record review, interviews and facility policy for 1 of 4 sampled residents (Resident #56) reviewed for accidents, the facility failed to complete neurological assessments after a fall, per facility policy for unwitnessed falls and for 1 of 1 sampled resident observed with medications at the bedside (Resident #88), the facility failed to administer medications according to standards of practice. The findings include:1.Resident # 56's was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, peripheral vascular disease, and hypertension. A nursing admission assessment (the admission Minimum Data Set assessment had not yet been completed) dated 1/29/25 identified Resident #56 was severely cognitively impaired and required assistance of 2 for bathing, transferring and personal care. The Resident Care Plan (RCP) dated 2/2/25 identified Resident #56 was at risk for falls due to multiple risk factors with intervention to toilet Resident #56 prior to dinner, encourage Resident #56 to ask and wait for staff assistance for transfers and/or toileting. a. A facility Accident and Incident report dated 2/2/25 at 5:00 PM identified Resident #56 was observed sitting on the floor in the lounge. No complaints of pain/discomfort or injuries were noted and the report identified it was an unwitnessed fall. A nursing note dated 2/2/25 at 5:50 PM identified Resident #56 was sitting on the floor in the lounge and had no visible injuries. Also identified neurological assessments were initiated per the facility protocols. On 8/4/25 at 12:00 PM, interview and review of the clinical record with the DNS failed to identify Neurological assessments were completed, despite the nursing note dated 2/2/25 at 5:50 PM indicating neurological assessments were initiated per the facility protocols. b. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 was severely cognitively impaired and required supervision with eating. Also identified Resident #56 required maximal assistance for toileting, bathing, personal hygiene, and transfers from bed to chair. Additionally, the MDS indicated Resident #56 had 2 or more falls since admission. A facility Accident and Incident report dated 3/4/25 at 2:15 PM identified Resident #56 had an unwitnessed fall. The report identified Resident #56 was observed lying on his/her right side in another resident's room. No injuries were noted. A nursing note dated 3/4/25 at 3:40 PM identified Resident #56 fell and was observed laying on the floor. Also, identifying the responsible party refused to have the resident sent out to the hospital to be evaluated for a neurological assessment. Interview and review of the Neurological Assessment flow sheet on 8/4/25 at 12:00 PM with the DNS identified 17 of 21 neurological assessments were not completed. c. A facility Accident and Incident report dated 3/6/25 at 6:50 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 was lying on the floor on his/her left side across from the nurse's desk and no injury was noted. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 3/6/25 at 8:53 PM identified Resident #56 was found, lying on his/her left side with no complaints of pain or discomfort. Also, identifying that neurological assessment should be monitored by the facilities protocol. Interview and review of the Neurological Assessment flow sheet on 8/4/25 at 12:00 PM with the DNS identified 16 of 21 neurological assessment were not completed. d. A facility Accident and Incident report dated 4/4/25 at 6:00 PM identified Resident #56 had a fall when he/she stood up and Resident #56 hit his/her head on the wall. Additionally, the report identified Resident #56's sustained a 3 centimeter contusion to his/her left upper forehead. A nursing note dated 4/4/25 at 8:11 PM identified Resident #56 had an unwitnessed fall. Additionally, the nursing note identified Resident #56 was seated in the hallway, eating dinner, got up quickly and fell forward, hitting his/her upper left forehead area sustaining a 3-centimeter laceration to the left side of his/her forehead. Also, identifying neurological status was observed. The family was notified and Resident #56 was sent to the emergency room. A nursing note dated 4/5/25 dated at 5:12 AM identified Resident #56 returned from the hospital at 1:25 AM. Neuros to be assessed and report any changes. On 8/4/25 at 12:00 PM, interview and review of the clinical record with the DNS failed to identify Neurological assessments were completed prior to or returning from the hospital. e. A facility Accident and Incident report dated 4/10/25 at 9:00 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 was found on his/her knees, by the bed. A nursing note dated 4/10/25 at 11:38 PM identified Resident #56 fell at 9:00 PM and was found on his/her floor mat by the bedside. Also, identifying Resident #56 was confused, forgetful, restless, refused vital checks, fighting anyone who came in contact with him/her, the Advanced Practice Registered Nurse was notified and Resident #56 was sent to the emergency room. A nursing note dated 4/11/25 at 1:39 AM identified Resident #56 returned to the facility. Also, identified Resident #56 had a small, raised area to the right side of his/her head. A copy of the Neurological Check flow sheet was provided which noted neurological assessments were not completed with a handwritten note across the top of the form identifying resident refused Neuro checks. Interview and review of the Neurological Check flow sheet with the DNS on 8/4/25 at 12:00 PM identified if a resident refused any neurological assessments, an attempt should be made to continue to try to obtain the assessments, and writing on the top of the form resident refused was not acceptable. f. A facility Accident and Incident report dated 4/12/25 at 4:30 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 was sitting on the floor against the wall in the hallway, no injury was noted. A nursing note dated 4/12/25 at 5:11 PM identified Resident #56 had a fall with no changes in his/her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurological or cardiovascular status. Interview and review of the Neurological Assessment flow sheet on 8/4/25 at 12:00 PM with the DNS identified 9 of 21 neurological assessments were not completed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 as severely cognitively impaired and was independent for eating. Also, identifying Resident #56 was dependent on oral hygiene, showering, and dressing. Further, identifying Resident #56 required moderate assistance for transfers. Additionally, the MDS identified Resident #56 had 1 fall with no evidence of injuries. g. A facility Accident and Incident report dated 6/9/25 at 6:55 PM identified Resident #56 had an unwitnessed fall. Additionally, the report identified Resident #56 bump to the back of head, in the hallway. A nursing note dated 6/9/25 at 9:21 PM identified Resident #56 was seen at 6:55 PM with his/her back against the wall in a seated position. Also, identifying Resident #56 had some redness noted on the left side of the head along with a raised area to the back of the head. Further, identifying Resident #56 was sent to the emergency room for evaluation. A nursing note dated 6/10/25 at 3:18 AM (approximately 5.5 hours after the fall) identified Resident #56 returned from the emergency room at 2:50 AM with a hematoma to the back of his/her head. Interview and review of the Neurological Check flow sheet with the DNS on 8/4/25 at 12:00 PM identified neurological assessments were initiated on 6/9/25 at 6:55 PM. Also, neurological assessments were not restarted once Resident #56 returned from the hospital on 6/10/25 at 2:50 AM (Resident #56 would have required every 4 hour neurological assessments at that time). Additionally, the DNS noted when a resident returns from the hospital the neurological assessment should be resumed. Review of the Neurological Checks policy identified neurological checks will be instituted as a nursing measure following a head injury. A resident that experiences an unwitnessed fall and was unable to accurately verbalize if she/he hit their head or experienced any type of head injury will have neurological checks instituted. Also, identifying a neurological check flow sheet would be instituted by the nurse. The checks will be completed as follows: every 15 minutes for the first hour then every hour for 4 hours then every 4 hours for the next 24 hours then, every shift for 48 hours after that. 2.Resident #88's diagnosis included dementia, depression, and anxiety disorder. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #88 was moderately cognitively impaired and was independent with personal hygiene, bathing, transfers, and toileting. The Resident Care Plan dated 7/11/25 identified Resident #88 having dementia with impaired memory, recall and decision-making skills. Interventions included to use simple terms and offer gentle reminders. Physician orders dated 7/20/25 directed the following medications were ordered and scheduled for administration at 8:00 AM and 9:00 AM: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Buspirone (a medication to treat depression) 10 mg tablet, give 1.5 tablets (15 mg dose) by mouth every morning 2. Pantoprazole (a medication to treat gastroesophageal reflux disease) 40 mg by mouth daily 3. Gabapentin (a medication to treat nerve pain) 300mg by mouth twice daily 4. Metoprolol (a medication to treat high blood pressure) 25 mg tablet, give .5 tablet (12.5mg dose) by mouth twice daily 5. Thiamine Mononitrate (a supplement)100 mg, give 2 tablets by mouth daily 6. Folic Acid (a supplement)1 mg by mouth daily in the AM 7. B12 tablet (a supplement), give 1 tablet by mouth daily in the AM 8. Furosemide (a medication to treat edema due to heart failure) 20 mg tablet, give 2 tablets (40mg dose) by mouth daily 9. Multivitamin tablet, give one tablet by mouth daily 10. Cholecalciferol (a Vitamin D supplement) 25 micrograms (mcg) by mouth once daily 11. K-[NAME] Con (a Potassium supplement)10meq, give 2 tablets, a 20milliequivalent (meq) dose by mouth daily Observation on tour at 7/28/25 at 11:09 AM, identified a clear plastic medication cup on Resident #88's bedside table with multiple medications (10 tablets and 1 capsule) contained in the cup. Resident #88 indicated that although he/she was not aware the medications were on the bedside table, the medication cup contained his/her morning medications and were likely left there by the nurse because he/she was out of the room. Resident #88 further identified the medications must have been from yesterday morning and were not left there by the nurse working today. A second observation made with LPN #1 on 7/28/25 at 11:15 AM identified a clear plastic medication cup on Resident #88's bedside table with multiple medications (10 tablets and 1 capsule) contained in the cup. LPN #1 identified that although she did not always stay with Resident #88 to ensure she takes all his/her medications, the medications found in the resident's room today were not the medications she administered to the resident, and she did not notice the medications were on the bedside table when in the room earlier. LPN #1 then called for the nursing supervisor to report the incident and further indicated the medications should not have been left with the resident or in the resident's room. A third observation made with the nursing supervisor (RN #1) on 7/28/25 at 11:19 AM identified a clear plastic medication cup on Resident #88's bedside table with multiple medications (10 tablets and 1 capsule) contained in the cup. RN #1 indicated the medications should not have been left at the bedside for Resident #88 and the nurse administering medications should have stayed with the resident and made sure the resident swallowed all the medications before leaving the room. RN #1 took possession of the medications and indicated she would further investigate and properly discard them with the DNS. A nursing progress note (director of nursing/DNS) dated 7/29/25 at 9:03AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified a late entry for 7/28/25 when Resident #88 had morning medications found at the bedside and stated they were for the previous day. The progress note indicated the APRN was made aware, the resident was responsible for self and education was provided for the nurse. The progress note identified Resident #88 had no ill effects after the medication error. A facility Reportable Event form dated 7/28/25 identified Resident #88 had morning (AM) medications found at the bedside, the Advanced Practice Registered Nurse (APRN) was notified, and the resident would be monitored. Review of the facility Medication Error Report dated 7/28/25 for Resident #88 identified all AM medications were found in a cup in the resident's room and the resident stated, they must have been from yesterday (7/27/25). The report indicated the error was discovered on rounds and the nurse should have ensured the medications were taken prior to leaving the resident's room. A nursing progress note (DNS) dated 7/29/25 at 9:03AM identified a late entry for 7/28/25 when Resident #88 had morning medications found at the bedside and stated they were from the previous day. The progress note indicated the APRN was made aware, the resident was responsible for self and education was provided for the nurse. The progress note identified Resident #88 had no ill effects after the medication error. Interview and review of the clinical record with the DNS on 7/31/25 at 11:35 AM identified she was aware of the medications found in Resident #88's room on 7/28/25. The DNS indicated the nurse administering medications should have stayed with the resident until all the medication was taken as a standard of practice. The DNS identified that although the resident may not have been in the room when medications were being passed, the nurse should not have left medications in the resident's room. Review of the clinical record with the DNS confirmed the medications and doses of the medications that were ordered to be administered at 8:00 AM and 9:00 AM daily and failed to identify Resident #88 was able to self-administer any oral medications. Interview and review of the clinical record with LPN #3 on 8/1/25 at 12:47 PM identified she had worked the morning of 7/27/25 and administered medications to Resident #88 which were ordered for 8:00AM and 9:00 AM. LPN #3 indicated Resident #88 usually took all medications in front of her and she did not recall any issues with the resident taking her medications on the morning of 7/27/25. LPN #3 identified that although the resident would sometimes be out of the room during her med pass, she would not have left medications in the resident's room and would have come back. Review of the clinical record with LPN #3 confirmed AM morning meds on 7/27/25 were administered and signed for by her. Review of the facility policy, Medication Administration, undated, directed all medications shall be administered safely and accurately in accordance with physician's orders, facility protocols, and applicable state and federal regulations.

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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** Based on clinical record review, observations, facility documentation, and interviews for 1 of 1 sampled resident (Resident #56) reviewed for edema, the facility failed to follow physician orders for applying compression stockings. The findings include:Resident # 56's diagnosis included Parkinson disease, peripheral vascular disease, and hypertension.The Resident Care Plan dated 4/16/25 identified Resident #56 had bilateral, pitting edema, interventions included to notify the physician if extremities become blue, red, swollen, hot, or any skin issues. Also, to encourage and assist Resident #56 to change position frequently.Review of the physician orders dated 4/23/25 directed to apply compression stockings in the AM and remove at hours of sleep every day and evening shift for edema.The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #56 as severely cognitively impaired and was independent for eating. Also, identified Resident #56 was dependent on oral hygiene, showering, and dressing. Further, identifying Resident #56 required moderate assistance for transfers.An observation was made on 7/29/25 at 9:51 AM of Resident #56 without compression stockings in place while out of [NAME] second observation was made on 7/29/25 at 2:40 PM of Resident #56 out of bed in a recliner chair without compression stockings and he/she was wearing only nonskid socks.A third observation was made on 7/30/25 at 9:28 AM Resident #56 was out of bed not wearing compression stockings and he/she was wearing only nonskid socks.An interview on 7/30/25 at 2:05 PM with the Licensed Practical Nurse (LPN) #2 identified compression stockings were not indicated on the Resident care card or RCP. Also, identifying a Nurse Aid (NA) would use the Resident care card to be directed to place the compression stockings on a resident. Further, identifying a resident should have 2 pairs of compression stockings but she could not find any in the resident's room and Resident #56 refused to wear the compression stockings this morning. Review of the Resident care cards with LPN#2 failed to have directions for the compression stockings to be applied every morning while resident was out of bed.An interview on 7/30/25 at 2:14 PM with Nurse Aide (NA) #8 identified Resident #56 only required nonskid socks to be applied.An interview on 7/30/25 at 2:38 PM with NA #7 who identified she was not aware Resident #56 was to wear compression stockings while out of bed. Also identifying the Resident care card would provide information regarding placing compression stockings on a resident.An interview on 7/31/25 at 11:27 AM with the Director of Nursing (DNS) identified Resident #56 had an order for compression stockings to be applied and the Resident Care card should have been updated to reflect the physician's order directing the use of compression stockings every day. An interview on 7/31/25 at 11:34 AM interview with Registered Nurse (RN) #8 identified the nurse on the unit was responsible for updating the care card on the unit when the order was first written on 4/23/25 to apply compression stockings every day for Resident #56 while out of bed. Further, identifying that all nursing staff can update the Resident care cards.Review of the Elastic Stockings Policy (Compression Stockings) identified the compression stockings were to improve circulation in the lower legs and to prevent pooling of blood in the lower extremities. Also, identifying Compression stockings are applied by nursing staff with a physician's order.Review of the Resident Profile/Care Cards policy purpose was to ensure information related to the resident's plan of care was communicated and available to all staff who assist the residents on a daily basis. Also identifying the Resident care cards will be updated by nursing staff as needed to reflect changes made to the resident's plan of care.Subsequent to this surveyor's inquiry the Resident care card was updated for the resident to wear compression stockings. Also, an observation of Resident #56 wearing compression stockings was made on 8/1/25 while out of bed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on the observations, facility policy, record review, and interviews for 1 of 1 sampled resident (Resident #88) observed on tour to have medication at the bedside, the facility failed to properly secure medications. The findings include:Resident #88's diagnosis included dementia, depression and anxiety disorder.The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #88 was moderately cognitively impaired and was independent with personal hygiene, bathing, transfers, and toileting.The Resident Care Plan dated 7/11/25 identified Resident #88 having dementia with impaired memory, recall and decision-making skills. Interventions included to use simple terms and offer gentle reminders.Physician orders dated 7/20/25 directed the following medications were ordered and scheduled for administration at 8:00 AM and 9:00 AM:1. Buspirone (a medication to treat depression) 10 milligram (mg) tablet, give 1.5 tablets (15 mg dose) by mouth every morning2. Pantoprazole (a medication to treat gastroesophageal reflux disease) 40 mg by mouth daily3. Gabapentin (a medication to treat nerve pain) 300 mg by mouth twice daily4. Metoprolol (a medication to treat high blood pressure) 25 mg tablet, give .5 tablet (12.5 mg dose) by mouth twice daily5. Thiamine Mononitrate (a supplement) 100 mg, give 2 tablets by mouth daily6. Folic Acid (a supplement)1 mg by mouth daily in the AM7. B12 tablet (a supplement), give 1 tablet by mouth daily in the AM 8. Furosemide (a medication to treat edema due to heart failure) 20 mg tablet, give 2 tablets (40 mg dose) by mouth daily 9. Multivitamin tablet, give one tablet by mouth daily10. Cholecalciferol (a Vitamin D supplement) 25 micrograms (mcg) by mouth once daily11. K-[NAME] Con (a Potassium supplement)10 milliequivalents (meq), give 2 tablets (20 meq dose) by mouth dailyObservation on tour at 7/28/25 at 11:09 AM, identified a clear plastic medication cup on Resident #88's bedside table with multiple medications (10 tablets and 1 capsule) contained in the cup. Resident #88 indicated that although he/she was not aware the medications were on the bedside table, the medication cup contained his/her morning medications and were likely left there by the nurse because he/she was out of the room. Resident #88 further identified the medications must have been from yesterday morning and were not left there by the nurse working today. A second observation made with LPN #1 on 7/28/25 at 11:15 AM identified a clear plastic medication cup on Resident #88's bedside table with multiple medications (10 tablets and 1 capsule) contained in the cup. LPN #1 identified that although she did not always stay with Resident #88 to ensure she takes all his/her medications, the medications found in the resident's room today were not the medications she administered to the resident, and she did not notice the medications were on the bedside table when in the room earlier. LPN #1 then called for the nursing supervisor to report the incident and further indicated the medications should not have been left with the resident or in the resident's room. A third observation made with the nursing supervisor (RN #1) on 7/28/25 at 11:19 AM identified a clear plastic medication cup on Resident #88's bedside table with multiple medications (10 tablets and 1 capsule) contained in the cup. RN #1 indicated the medications should not have been left at the bedside for Resident #88 and the nurse administering medications should have stayed with the resident and made sure the resident swallowed all the medications before leaving the room. RN #1 took possession of the medications and indicated she would further investigate and properly discard them with the DNS. A facility Reportable Event form dated 7/28/25 identified Resident #88 had morning (AM) medications found at the bedside, the Advanced Practice Registered Nurse (APRN) was notified, and the resident would be monitored. Review of the facility Medication Error Report dated 7/28/25 for Resident #88 identified all AM medications were found in a cup in the resident's room and the resident stated, they must have been from yesterday (7/27/25). The report indicated the error was discovered on rounds and the nurse should have ensured the medications were taken prior to leaving the resident's room. A (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075345	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing progress note (DNS) dated 7/29/25 at 9:03AM identified a late entry for 7/28/25 when Resident #88 had morning medications found at the bedside and stated they were from the previous day. The progress note indicated the APRN was made aware, the resident was responsible for self and education was provided for the nurse. The progress note identified Resident #88 had no ill effects after the medication error. Interview and review of the clinical record with the DNS on 7/31/25 at 11:35 AM identified she was aware of the medications found in Resident #88's room on 7/28/25. The DNS indicated the nurse administering medications should have stayed with the resident until all the medication was taken as a standard of practice. The DNS identified that although the resident may not have been in the room when medications were being passed, the nurse should not have left medications in the resident's room. Review of the clinical record with the DNS confirmed the medications and doses of the medications that were ordered to be administered at 8:00 AM and 9:00 AM daily and failed to identify Resident #88 was able to self-administer any oral medications. Interview and review of the clinical record with LPN #3 on 8/1/25 at 12:47 PM identified she had worked the morning of 7/27/25 and administered medications to Resident #88 which were ordered for 8:00AM and 9:00 AM. LPN #3 indicated Resident #88 usually took all medications in front of her and she did not recall any issues with the resident taking her medications on the morning of 7/27/25. LPN #3 identified that although the resident would sometimes be out of the room during her med pass, she would not have left medications in the resident's room and would have come back. Review of the clinical record with LPN #3 confirmed AM morning meds on 7/27/25 were administered and signed for by her. Review of the facility policy, Medication Storage in the Facility, undated, directed medications are stored safely, securely, and properly. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications are allowed unsupervised access to medications and medication supplies are to be locked or attended to by persons with authorized access. Review of the facility policy, Medication Administration, undated, directed all medications shall be administered safely and accurately in accordance with physician's orders, facility protocols, and applicable state and federal regulations.

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, facility documentation, and facility policy for 1 of 2 residents (Resident #31) reviewed for personal funds, the facility failed to provide quarterly statements to the resident representative for a resident that was severely cognitively impaired. The findings include:Resident #31's diagnoses included hemiplegia and hemiparesis following other cerebrovascular disease, anoxic brain damage, and localization-related (focal)(partial) idiopathic epilepsy.Review of Resident #31's admission record identified Resident #31 was admitted to the facility on [DATE] and listed Person #1 as the resident representative.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #31 was severely cognitively impaired and was dependent on staff for self-care and transfers.The Resident Care Plan dated 6/21/25 identified Resident #31 had impaired memory, recall, and decision-making skills related to cerebrovascular incident and anoxic brain damage. Interventions included using short and simple sentences, offer support and reassurance if resident appeared anxious, and to offer one step at a time directions. Additionally, the care plan identified Resident #31 had difficulty understanding and/or expressing speech. Interventions included to be patient and reassure as needed, keep communications simple, and to use gestures and other non-verbal techniques to enhance communication.Interview with Person #1 on 7/29/25 at 9:35 AM identified that they had not received a quarterly statement for Resident #31 personal funds account since the resident was admitted to the facility.Interview and review of the Resident Trust Accounts with the Regional Business Office Manager on 8/1/25 at 2:39 PM identified Resident #31 had a balance of $170.33 in the Resident Trust Account at the facility. Additionally, the Regional Business Office Manager identified resident personal funds quarterly statements were mailed out on the 15th of every month to the resident or resident representative and that it was the responsibility of the Business Office Manager. Additionally, the interview identified that Resident #31's quarterly statements had been sent to the resident and that they should have been sent to Person #1 as the resident was severely cognitively impaired.Subsequent to surveyor inquiry, the address was edited on the resident's personal fund so that statements would be sent to Person #1.Review of the facilities Resident Trust Fund Policy, dated 10/1/2020, identified that on a quarterly basis, the facility must provide the resident or responsible party with an accounting of the resident's financial transactions made by the facility on their behalf.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and facility policy for 2 of 3 residents (Resident #27 and Resident #28) reviewed for hospitalization, the facility failed to ensure a Notice Regarding Reservation of a Resident's Bed notice of the policy about reserving the resident's bed while they are hospitalized) was provided to the resident representative per policy. The findings include: 1. Resident #27 had diagnoses that included dementia, bipolar schizoaffective disorder, and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 was severely cognitively impaired and independent with eating, transfers, and ambulation.The Resident Care Plan (RCP) dated 4/21/25 identified Resident #27 was at risk for changes in mood state and behaviors related to schizoaffective disorder. Interventions included follow-up with the psychiatric provider as scheduled and as needed, and watch for and report new onset or increased symptoms such as delusions, hallucinations, and bizarre or unusual behavior.A nursing note written by Registered Nurse (RN) #8 dated 6/12/25 at 1:23 PM identified Resident #27 was screaming and yelling loudly about his/her family member not calling yet and staff were unable to calm him/her down. The note identified Resident #27 expressed suicidal ideations and was placed on 1 to 1 observation with Social Worker (SW) #1. The note identified Advanced Practice Registered Nurse (APRN) #2 was notified of Resident #27 expression of suicidal ideations and an order to send to the hospital was given. The note identified Resident #27's resident representative/family member was notified of the need to transfer Resident #27 to the hospital. The note failed to identify the resident representative or family member was provided a Notice Regarding Reservation of a Resident's Bed.A nursing note written by Licensed Practical Nurse (LPN) #4 dated 6/12/25 at 2:11 PM identified Resident #27 was restless, screaming, and hitting staff. The note identified Resident #27 was unable to be redirected and disrupted other residents and was sent to the hospital for evaluation. The note failed to identify a Notice Regarding Reservation of a Resident's Bed was provided to the responsible party or family.A social service note written by SW #1 dated 6/12/25 at 4:14 PM identified Resident #27 was sent to the hospital after a long episode of screaming and that SW #1 would follow-up with Resident #27 as needed. The note failed to identify the resident representative was notified either verbally or by mail of the bed hold policy. Review of nursing notes from 6/12/25 through 7/15/25 failed to identify Resident #27's resident representative or family member had been provided and/or mailed a Notice Regarding Reservation of a Resident's Bed.2. Resident #28 had diagnoses that included chronic obstructive pulmonary disease (COPD), dementia, and epilepsy.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 was cognitively intact, independent with eating, required partial/moderate assistance with bed mobility and was dependent with transfers.The Resident Care Plan (RCP) dated 4/9/25 identified Resident #28 was at risk for respiratory distress and ineffective breathing patterns related to COPD. Interventions included if Resident #28 had increased cough, congestion, wheezing, or shortness of breath to notify the physician or Advanced Practice Registered Nurse (APRN).A nursing note written by Registered Nurse (RN) #12 and dated 4/13/25 at 4:29 PM identified Resident #28 had respiratory distress, a chest x-ray positive for a left basilar infiltrate, and an elevated white blood cell count. The note identified APRN #3 was notified and directed to send Resident #28 to the hospital for evaluation and treatment. The note further identified APRN #3 indicated she would call the hospital to give a status report and she would call and inform Resident #28's family of the need for his/her transfer to the hospital. The note failed to identify a Notice Regarding Reservation of a Resident's Bed was provided to the resident representative or family.Review of nursing notes from 4/13/25 through 4/17/25 failed to identify Resident #28's resident representative or family member had been provided and/or mailed a Notice Regarding Reservation of a Resident's Bed.Interview with RN #1 on 8/1/25 at 12:36 PM identified the nursing (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	supervisor was responsible for sending a resident to the hospital and for preparing the necessary documents sent to the hospital with the resident. RN #1 identified the Notice Regarding Reservation of a Resident's Bed (CT) was a new form and she would provide a copy of the notice to the social service department. Additionally, RN #1 identified she would not document in a nursing note that the notice had been provided to the resident/responsible party because a copy was given to the social service department.Interview with Social Worker #1 on 8/1/25 at 12:50 PM identified she did not receive any Notice Regarding Reservation of a Resident's Bed forms from the nursing staff after a resident was transferred to the hospital and she was not familiar with the notice.Interview with Director of Nursing (DNS) on 8/1/25 at 1:00 PM identified the Notice Regarding Reservation of a Resident's Bed was not new, but the notice had been reformatted. The DNS identified Social Worker #1 should be familiar with the notice, but that the notice did not go to her. The DNS identified the notice was sent to the hospital with the resident in a red envelope and the resident representative would be told of the Notice Regarding Reservation of a Resident's Bed when the nursing staff called to notify them of the resident's need for emergency transfer to the hospital. The DNS further identified a copy of the Notice Regarding Reservation of a Resident's Bed should be made and put in the resident's chart or a nursing note identifying the notice had been provided to the resident/resident should be written in the electronic medical record. The DNS was unable to identify the reason a copy of the notice wasn't made and put in the clinical record or a note wasn't written stating the notice was provided.Review of the Notice Regarding Reservation of a Resident's Bed policy directed, in part, bed reservation guidelines for Medicaid residents with a hospital transfer and guidelines for private pay residents with a hospital transfer. The policy includes a signature line for the resident/responsible party to sign and date the form. Additionally, the policy includes at the bottom a section to be filled out when the notice is mailed to the responsible party or sent with the resident to the hospital identifying which option was chosen and who sent the notice and the date it was sent. The policy failed to identify direction to staff to make and retain a copy of the notice for reference.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and interviews for 1 of 1 sampled resident (Resident #56) reviewed for a change in condition, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment when Resident #56 entered into hospice services. The findings include:Resident #56's diagnosis included Parkinson disease, peripheral vascular disease, and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 was severely cognitively impaired and was independent for eating. Also, identifying Resident #56 was dependent for oral hygiene, showering, dressing and required moderate assistance for transfers.Physician orders dated 6/18/25 at 9:45 AM directed for a hospice consultation.A Social Worker note dated 6/19/25 at 4:26 PM identified Resident #56 was approved for hospice services for Parkinson's disease. The Hospice agency arranged to meet with the family tomorrow at the facility to review and sign consent forms to begin services on 6/20/25 (the following day).A Social Worker note dated 6/20/25 at 12:05 PM identified Resident #56 started hospice services.Nursing notes dated 6/20/25 at 1:41 PM identified Resident #56 was admitted to hospice services.The Resident Care Plan dated 6/25/25 identified hospice care with interventions that included to provide emotional support to patient and family, control pain, symptoms and maintain dignity.Interview with Registered Nurse (RN) #8 on 7/31/25 at 11:15 AM identified the last MDS completed was a quarterly MDS on 5/28/25 and a Significant Change assessment was not completed when Resident #56 transferred to hospice care services. Also, RN #8 identified that she did not think going on hospice services was a Significant Change for the resident therefore a Significant Change assessment was not necessary.Interview with RN #9 on 7/31/25 at 11:20 AM identified a Significant Change assessment should have been completed when Resident #56 transferred to hospice services. Also, identifying per the Resident Assessment Instrument (RAI) Manual the facility has up to 14 days to complete the significant change MDS and she was unsure of why it was not completed within 14 days of 6/20/25.As per the RAI OBRA required to ensure that each resident who experiences a significant change in status is comprehensively assessed using the CMS-specified Resident Assessment Instrument (RAI) process. Significant Change is a major decline or improvement in a resident's status that 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered self-limiting (NOTE: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.); 2) impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan. This does not change the facility's requirement to immediately consult with a resident's physician of changes as required under 42 CFR 483.10(i)(14), F580. Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline.