STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075380	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Cromwell	156 Berlin Road Cromwell, CT 06416

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who was dependent on staff for personal hygiene and incontinent care, the facility failed to follow the physician's orders for two (2) staff to assist the resident when being turned from side to side during care which resulted in a fall off the bed and the resident sustaining a laceration to the head. The findings include: Resident #1's diagnoses included hemiplegia and hemiparesis affecting the right side after a stroke, atrial fibrillation, morbid obesity, aphasia, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS) indicating Resident #1 rarely or never made decisions, was dependent on staff for all activities of daily living, required maximum assistance for turning and repositioning when in bed, was incontinent of bowel and bladder, and received an anticoagulant (a blood thinning medication). The Resident Care Plan dated 10/10/24 identified Resident #1 had a self-care deficit due to a history of a stroke with a right sided deficit, was always incontinent of bowel and bladder, and at risk for falls. Interventions directed side rails per physician's orders to assist with bed mobility, call bell in reach, incontinent care per policy, and assistance with turning and repositioning. The nursing admission assessment dated [DATE] identified Resident #1 was re-admitted to the facility after a hospitalization. The assessment indicated Resident #1 was an assist of two (2) with positioning and incontinent of bowel and bladder. A physician's order dated 12/9/24 directed total mechanical lift for transfers, and assistance of two (2) staff for bed level activities of daily living and incontinent care. The nurse's note dated 12/14/24 at 6:20 AM identified the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1, responded to a 11PM-7AM nurse aide, Nurse Aide (NA) #1, calling for help. Upon entering Resident #1's room, RN #1 noted Resident #1 laying on his/her right side with the head was up against the nightstand and blood was coming from the right side of the head. Emergency Medical Service (EMS) was called and Resident #1 was transferred to the hospital for further evaluation. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurse's note dated 12/14/24 at 7:32 AM identified the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #2, was called to Resident #1's room. The note indicated Resident #1 was observed on the floor after falling off the bed during incontinent care. The Resident Care Card prior to the 12/14/24 incident, last updated on 3/11/24, failed to identify the number of staff needed for assistance with turning and repositioning and incontinent care. The December 2024 Treatment Administration Record identified staff documented Resident #1 was an assist of two (2) with bed level activities of daily living and incontinent care. The hospital record dated 12/14/24 identified Resident #1 sustained a scalp laceration. The nurse's note dated 12/14/24 at 1:19 PM identified Resident #1 returned from the hospital with five (5) staples to the right side of the scalp. Interview with the Director of Nursing (DON) on 1/6/25 at 11:50 AM identified on 12/9/24 when Resident #1 returned from a short hospital stay the physical therapist, (PT) #1 assessed Resident #1 and obtained an order for Resident #1 to be a two (2) person assist for incontinent care. The DON identified PT #1 should have updated the nurse aide Resident Care Card. The DON identified at the time of the fall on 12/14/24, two (2) staff should have been assisting Resident #1. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 1/6/25 at 12:10 PM identified she worked with Resident #1 on a regular basis and the resident had been a two (2) person assist for as long as she could recall due to Resident #1's body size and right sided weakness. LPN #1 identified she had assisted NA #1 with Resident #1's incontinent care in the past when she worked the 11PM-7AM shift. Interview with the physical therapist, PT #1, on 1/6/25 at 12:25 PM identified upon return from the hospital on [DATE] she assessed Resident #1 and noted Resident #1 continued to require assistance of two (2) for all bed level care due to the resident's body size and non-functional right side. PT #1 explained an assist of one (1) staff during care would not have been safe. PT #1 identified she wrote the order on 12/9/24 because all orders need to be rewritten when a resident returns from the hospital. PT #1 also identified that she updated the Resident Care Card, however she was unable to locate a copy. Interview with the 7AM-3PM nurse aide, NA #2, on 1/6/25 at 12:45 PM identified she worked with Resident #1 on a regular basis, and someone always helped her when providing incontinent care. NA #2 explained a staff member would stand on either side of the bed acting as a barrier when rolling the resident from side to side and Resident #1 was an assist of two (2) during care for as far back as she could recall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #1 on 1/6/25 at 1:00 PM identified she had provided care for Resident #1 for the past eighteen (18) months, the only time she requested assistance when providing incontinent care was if Resident #1 was exhibiting an increase in behaviors, otherwise she provided care alone because the Resident Care Card did not say assist of two (2). NA #1 indicated on 12/14/24 she assisted Resident #1 with incontinent care. NA #1 explained she turned Resident #1 onto the right side, had the resident hold the bed rail with the left hand, stood behind the resident and washed the resident's back, she then placed Resident #1 on his/her back, walked to the other side of the bed, positioned Resident #1's right leg over the left leg, had the resident hold the bed rail with the left hand and as she pulled the pad towards her to turn Resident #1 onto the resident's left side, Resident #1's right leg swung forward and propelled Resident #1 feet first onto the floor and Resident #1 sustained a laceration to the right side of the head. The facility policy, Positioning, identified residents who are unable to position themselves are repositioned in accordance with his/her individual needs and that the Resident Care Card would indicate that the resident needs assistance with positioning. The facility policy, care Planning, identified the Resident Care Card would be updated as needed to reflect changes made to the resident's plan of care.