| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab Cromwell | 156 Berlin Road<br>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 0575<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.<br><br>50249<br><br>Based on observations and staff/resident interviews regarding required postings, the facility failed to<br><br>ensure the required information related to contact information and how to file a complaint to the State Agency was posted in the facility. The findings include:<br><br>On 4/1/24 at 2:00 PM during the Resident Council meeting, Resident #10 stated he/she was not aware of how to file a grievance or make a complaint. Additionally, Resident #10 stated he/she had not observed information within the facility to direct him/her on how to make a complaint regarding his/her care.<br><br>Subsequent to the Resident Council Meeting, on 4/1/24 at 3:40 PM, observations were made on all units of the facility which failed to identify that a statement and contact information on how to make a complaint to the State Survey Agency had been posted/displayed.<br><br>The Administrator on 4/2/24 at 2:00 PM, was unable to provide a facility policy for making residents aware of how to contact the State Agency and stated she would have to see if there was a policy. Additionally, the Administrator failed to identify that the required statement and contact information on how to make a complaint to the State Survey Agency had been posted in the facility. The Administrator further identified that she should have posted the information and that she would make sure she posted it within the facility.<br><br>Subsequent to surveyor inquiry, an observation on 4/2/24 at 3:10 PM identified that the Administrator posted a sign on the [NAME] Wing of the facility and the required statement and contact information on how to make a complaint to the State Survey Agency was included on the posting. |

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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100<br><br>Based on review of the clinical record, facility policy, and interviews for 3 of 24 residents (Resident #69, Resident #474, and Resident #572) reviewed for Advance Directives, the facility failed to obtain Advance Directives upon admission and failed to ensure the resident's preference was honored according to the physician order. The findings include:<br><br>1. Resident #69's diagnoses included emphysema, chronic obstructive pulmonary disease, and urinary tract infection.<br><br>Review of the written Advance Directive Form dated [DATE] and signed by Resident #69 and LPN #3 directed a Do Not Resuscitate (DNR) status. The form lacked the physician's signature.<br><br>A physician's order dated [DATE] directed facility staff to perform Cardiopulmonary Resuscitation (CPR) in the event of a change in status (a discrepancy with the written Advance Directive Form which indicated DNR).<br><br>The Resident Care Plan dated [DATE] indicated Advanced directives per resident/representative and per the physician orders.<br><br>A Nurse Practitioner Note dated [DATE] identified, in part, Advanced Care Planning, that Resident #69's preference was for a full code (resuscitation).<br><br>Interview with the Director of Nursing (DNS) on [DATE] at 4:00 PM identified that the Advance Directive form signed by the resident reflected the resident's preference to be a DNR and could not explain why the physician order did not reflect the the resident's preference for a DNR, but indicated Resident #69 should be resuscitated in the event of a change in condition.<br><br>2. Resident #474's diagnoses included visual impairment, muscle weakness, and stroke.<br><br>The admission nursing assessment dated [DATE] identified Resident #474 was cognitively intact, needed assistance of 2 staff for transfers, and needed supervision for completing personal hygiene.<br><br>A physician's order dated [DATE] directed to provide cardiopulmonary resuscitation (CPR).<br><br>A nurse's note dated [DATE] documented Resident #474 wanted to receive CPR if his/her heart were to stop beating.<br><br>Review of Resident #474's clinical record identified an incomplete medical intervention consent form (advance directive) and only the resident's name had been written on the form.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview with the DNS on [DATE] at 1:27 PM identified that the medical intervention consent form (advance directive) should be signed within 24 hours of a resident's admission to the facility and that it is the admitting nurse's responsibility to ensure the form was completed and signed. The DNS was unable to explain why the admitting nurse failed to complete the advance directive within 24 hours.<br><br>Interview with RN #2 on [DATE] at 2:40 PM identified that when Resident #474 was admitted , RN #2 began the advance directive process by writing the resident's name and the date ([DATE]) on the form, however, RN #2 realized Resident #474 had a visual impairment and believed the resident should sign the form in the presence of a family member. RN #2 explained that she held onto the incomplete advance directive form, intending for Resident #474 to complete and sign it with a family member present, however, no family member visited during any of RN #2's shifts and the form remained unsigned. RN #2 indicated that she was aware of the facility's policy to complete and date an advance directive within 24 hours of admission.<br><br>Interview with the DNS and RN #5 on [DATE] at 2:15 PM indicated they were aware of the incomplete advance directive form in Resident #474's clinical record. They reported the form they observed in the chart included the resident's name but did not include a date. Subsequent to surveyor inquiry, the DNS requested RN #2 to complete the form with Resident #474 on [DATE], which was promptly completed and returned. The newly completed form had been dated [DATE] (the date due), but neither the DNS nor RN #5 were able to explain why the form was back dated to [DATE] but should have been dated on the day of Resident #474's completion.<br><br>Review of the Advance Directive policy (dated [DATE]), directed, in part, to review advance directives with the resident upon admission to the facility and to keep the completed form in the resident's medical record.<br><br>3. Resident #572 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, congestive heart failure, and depression.<br><br>A Nursing Admission assessment dated [DATE] identified Resident #572 was able to recall the current season, that he/she was in a nursing home, and the location/room. Resident #572 required a two person assist and a device for ambulation, was independent with eating, and was continent of both bowel and bladder.<br><br>An admission nurse's note written by RN #4 and dated [DATE] at 5:59 PM identified Resident #572 was a Do Not Resuscitate (DNR).<br><br>A History and Physical dated [DATE] and completed by the physician identified that either the resident or the Power of Attorney (POA) needed to sign the directives advising of the code status.<br><br>The Resident Care Plan dated [DATE] identified the need for staff assistance with activities of daily living related to cardiac issues. Interventions included Advance Directives per physician orders, assist as needed to meet toileting needs, and to deliver meals with set up as needed.<br><br>Interview with the Director of Nursing Services (DNS) on [DATE] at 1:27 PM identified that a Medical Interventions Consent Form (which identified code status) was to be completed within 24 hours of admission and if a decision was not made, the resident would be considered a full code.<br><br>(continued on next page) |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview and clinical record review with RN #3 on [DATE] at 2:12 PM identified Resident #572 was his/her own responsible party and that he/she was a full code since the admission paperwork, including the Medical Interventions Consent Form, was not completed (an inconsistency with the admission nursing note dated [DATE] that stated Resident #572 was a DNR). Additionally, RN #3 identified that the facility's policy was to have the paperwork for code status completed upon admission, that the completed Medical Interventions Consent Form would be reviewed by the physician, and that an order regarding code status would be received.<br><br>Interview and clinical record review with RN #4 on [DATE] at 10:28 AM identified that when Resident #572 was admitted , she received report from the hospital which indicated the resident was a DNR. Additionally, RN #4 identified that she was unable to have the admission paperwork completed during her shift, and that she gave report to the nurse working the next shift to complete the paperwork.<br><br>Subsequent to surveyor inquiry, the Medical Interventions Consent Form was completed by Resident #572 on [DATE] indicating a decision of DNR/Do Not Intubate (DNI) and no tube feeding. A physician's order regarding code status was received [DATE] which directed the same.<br><br>Review of the Advance Directives policy directed, in part, that upon admission to the facility, advance directives are reviewed with the resident and/or the resident's substitute decision maker(s) by the healthcare provider. If a decision is made regarding advance directives, the advance directive consent form would be signed and dated by the resident or substitute decision maker(s), and the person who explained advance directives. The advance directive consent form would be kept in the resident's medical record. A physician's order would be obtained regarding the advance directives. If no decision was made related to advance directives, the resident would remain a full code until a decision was made by the or substitute decision maker(s).<br><br>50095<br><br>50177<br><br>50179 |

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|---|---|
| F 0584<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879<br><br>Based on observations and interviews for 1 of 3 nursing units observed for environment, the facility failed to ensure the building was maintained in a clean, comfortable home-like manner. The findings included:<br><br>During the initial facility tour, observation on 3/27/24 at 10:41 AM on the North Unit the following was identified:<br><br>a. Resident #3's call bell at the junction of the cord that connects to the wall was duct taped to the wall in two areas.<br><br>b. room [ROOM NUMBER]-B was observed with a hole in the tile flooring (approximately 6 inches by 2 inches) to the left of the bed by the window.<br><br>c. The shower room, utilized by 24 residents, was observed with several wooden pallets that were noted on the floor, topped with boxes of supplies (approximately 46 boxes containing incontinent briefs).<br><br>Interview with the Director of Maintenance on 3/27/24 at 2:11 PM identified that the Maintenance Department was responsible for maintaining the overall upkeep of the building and that they rely on the staff to notify them when items are in need of repair. He indicated he had not been aware that Resident #3's call bell had been duct taped into the wall and that if maintenance had been notified, they would have replaced the call bell right away. Additionally, he indicated he had not been aware of the hole in the floor of room [ROOM NUMBER]-B, stating there used to be a dresser where it was located. He did not identify the reason the shower room was stacked with boxes, but indicated they shouldn't have been stored on the floor.<br><br>Re-interview and tour of the North Unit on 4/1/24 at 2:23 PM with the Director of Maintenance, identified the North Unit shower room leaking into the conference room next door. Grout and caulking were missing from the joints of the tile in the shower. He identified he would get it fixed as soon as possible. He noted that facility Environmental Rounds are completed every 2 months with the Infection Control Nurse, but that she resigned over a month ago and rounds have not been performed since. He identified that the last facility Environmental Rounds were completed on 1/19/24, and that he had not been notified by staff, nor did they identify any of the items brought to his attention by the surveyor's regarding the shower room, Resident #3's call light, or room [ROOM NUMBER]'s hole in the floor .<br><br>Subsequent to surveyor inquiry, Resident #3's call bell was replaced, the floor was repaired in room [ROOM NUMBER]-B, and additional shelving was installed in the North Unit shower room to house the boxes that were on the floor.<br><br>Although requested, the facility failed to provide an environmental condition and/or repair policy. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249<br><br>Based on staff interviews, record review, review of facility documentation and facility policy for 1 of 2 sampled residents (Resident #13) reviewed for mistreatment, the facility failed to ensure Resident #13 was not treated in a scolding manner. The findings include:<br><br>Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 2 persons with transfers and toileting.<br><br>The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings.<br><br>On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you?<br><br>On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the Investigation Summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her.<br><br>The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me?<br><br>Interview with the DNS on 4/4/24 at 3:00 PM identified that after her review of the incident, NA #3 approached Resident #13 to confront him/her about stating that NA #3 was not providing him/her care. The DNS further identified that the incident could be classified as abuse due to willful action and confrontation by NA #3. Additionally, the DNS identified that the Administrator was a witness to the incident and that the Administrator intervened with getting assistance from another staff person for Resident #13 on the day it occurred.<br><br>Interview with NA #2 on 4/9/24 at 11:30 AM identified that on the afternoon of 2/22/24 she observed NA #3 in the dining room with Resident #13. NA #2 further identified that she observed NA #3 turn Resident #13's wheelchair, pointed her finger in Resident #13's face and yelled You should have waited, I told you to wait. Upon leaving the dining room, NA #2 indicated that she immediately reported the incident to the Administrator.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview with NA #3 on 4/9/24 at 11:45 AM identified that Resident #13 had a habit of telling people that she does not take him/her to the bathroom and that on 2/22/24 she asked Resident #13 why he/she was telling people she would not toilet him/her. She further identified that Resident #13 started yelling at her and that she did not recall shaking her hand at Resident #13.<br><br>Interview and record review with the DNS on 4/9/24 at 12:15 PM indicated that NA #3 was given a written disciplinary action by the Administrator on 2/27/24. The DNS provided the documentation on the Facility's Investigation Summary Form/The Conclusion (undated) which identified that the facts in the investigation supported the allegation of verbal harassment by NA #3.<br><br>Review of the facility policy, [NAME] of Rights/Residents (undated), directed that residents shall be treated according to the guidelines in the Resident's [NAME] of Rights at all times. Review of the Resident's [NAME] of Rights (undated) identified that residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249<br><br>Based on staff interviews, record review, review of facility documentation and facility policy for 1 of 2 sampled residents (Resident #13) reviewed for mistreatment, the facility failed to prevent a Nurse Aide (NA #3) from working during an investigation of mistreatment. The findings include:<br><br>Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 2 persons with transfers and toileting.<br><br>The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings.<br><br>On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you?<br><br>On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the investigation summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her.<br><br>The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me?<br><br>Interview on 4/4/24 at 3:00 PM with the DNS identified that the incident was brought to her attention on 2/28/24 and that was when she formally initiated the investigation. The DNS indicated that the Administrator was a witness to the incident on 2/22/24 and that the Administrator did not notify her of the event until several days later. The DNS identified that NA #3 was allowed to work at the facility between 2/22/24 and 2/28/24.<br><br>Interview with NA #3 on 4/9/24 at 11:45 AM identified that she was not directed to stay home from work after the incident and that she worked at the facility on 2/27/24 and 2/28/24. NA #3 indicated that on both 2/27/24 and 2/28/24, she worked on the floor and was assigned to take care of residents but that she was not assigned Resident #13.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview and record review with the DNS on 4/9/24 at 12:15 PM identified that she was unsure what date the investigation was fully completed for the incident on 2/22/24, but that some of the witness statements for the investigation were obtained on 2/28/24. Additionally, the DNS identified that the facility timecard provided for NA #3 was accurate and that NA #3 had worked in the facility on 2/27/24 and 2/28/24. The DNS identified that she would not have expected that NA #3 would have been allowed to work in the facility after the incident was reported on 2/22/24. Additionally, the DNS indicated that in response to this incident and in her absence, the staffing schedule for NA #3 should have been adjusted by the Administrator.<br><br>Although attempted, an interview with the Administrator could not be obtained.<br><br>Review of the facility policy, Abuse/Resident dated 7/23/23, directs abuse or mistreatment of any kind toward a resident as strictly prohibited and that the individual accused will be immediately suspended without pay, pending the findings of the investigation. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177<br><br>Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 4 residents (Resident #13 and Resident #40) reviewed for timeliness of providing Activities of Daily Living (ADLs), the facility failed to report an allegation of mistreatment to the State Agency. The findings include:<br><br>1. Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder.<br><br>The annual Minimum Data Set (MDS) dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 1 with transfers and toileting.<br><br>The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings.<br><br>On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you?<br><br>On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the Investigation Summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her.<br><br>The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me?<br><br>Interview and record review on 4/1/24 at 3:30 PM with the DNS identified that she was aware of an incident on 2/22/24 with Resident #13 and NA #3. The DNS provided the Facility's Investigation Summary form for the incident on 2/22/24 and indicated that the incident was not reported to the State Agency and did not know the reason the incident was not reported to the State Agency.<br><br>Interview on 4/4/24 at 3:00 PM with the DNS identified that the incident was brought to her attention on 2/28/24 and that was when she formally initiated the investigation. The DNS indicated that the Administrator was a witness to the incident and that the Administrator did not notify her of the event until several days later. The DNS further identified that she was aware that she or the Administrator should have reported the alleged allegation of mistreatment to the State Agency within two hours of notification.<br><br>Although attempted, an interview with the Administrator could not be obtained.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab Cromwell | 156 Berlin Road<br>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.

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Subsequent to surveyor inquiry, the DNS reported the incident from 2/22/24 to the State Agency.<br><br>2. Resident #40's diagnoses included polyneuropathy, epilepsy, and adjustment disorder.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was without cognitive impairment and required partial/moderate assistance with personal hygiene, substantial/maximal assistance with bathing, and total dependence with toileting.<br><br>The Resident Care Plan dated 1/15/24 identified the need for staff assistance with ADLs and that Resident #40 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included to assist as needed to meet toileting needs, incontinent care per policy, that Resident #40 requested not to be woken up during the night but would use the call bell when he/she needed to be changed, and to keep skin clean and dry, applying barrier cream with incontinent care.<br><br>A Complaint Submission to the Department of Public Health (DPH) Facility Licensing and Investigations Section dated 3/28/24 identified that on 1/28/24, Resident #40 laid in an extremely wet incontinent brief and pad from 2:00 AM until 6:30 AM and on the following day 1/29/24, Resident #40 laid in a feces filled brief from 2:40 PM until 3:20 PM before being changed. He/she voiced concern of developing a urinary tract infection.<br><br>Interview with the Director of Nursing Services (DNS) on 4/2/24 at 1:00 PM indicated that she was unaware of Resident #40's complaints from 1/28/24 and 1/29/24. The DNS was made aware of these complaints by the Stage Agency surveyor on 4/2/24 at 1:00 PM.<br><br>Interview with the DNS and [NAME] President (VP) of Clinical Services on 4/3/24 at 1:45 PM identified that no Reportable Event document for these complaints had been completed. The VP of Clinical Services advised that they have the right to gather data before submitting the report to the Stage Agency and that they were still looking into it.<br><br>Review of the facility's Abuse policy directed, in part, that the Administrator/DNS or designee would immediately conduct an investigation upon submission of a report to the DPH Facility Licensing and Investigations Section within 2 hours of notification of alleged allegation of abuse.<br><br>50249 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249<br><br>Based on staff interviews, record review, review of facility documentation and facility policy for 1 of 2 sampled residents (Resident #13) reviewed for mistreatment, the facility failed to complete a thorough investigation after an allegation of mistreatment. The findings include:<br><br>Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder.<br><br>The annual Minimum Data Set (MDS) dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 2 with transfers and toileting.<br><br>The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings.<br><br>On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you?<br><br>On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the Investigation Summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her.<br><br>The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me?<br><br>Interview on 4/1/24 at 3:30 PM with the DNS identified that she was aware of an incident on 2/22/24 between Resident #13 and NA #3. The DNS provided the Facility's Investigation Summary form (undated) for the incident on 2/22/24, which identified that the investigation was not immediately initiated or conducted timely. The DNS further indicated that she did not know the reason the incident was not investigated, but that care was provided to Resident #13.<br><br>Interview on 4/4/24 at 3:00 PM with the DNS identified that the incident on 2/22/24 was brought to her attention on 2/28/24 and that was when she formally initiated the investigation. The DNS identified that the Administrator was a witness to the incident on 2/22/24 and that the Administrator intervened but did not notify her of the incident until several days later and did not initiate an investigation on 2/22/24. The DNS further indicated that she was aware that the investigation should have been initiated immediately.<br><br>(continued on next page) |

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| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview and record review with the DNS on 4/9/24 at 12:15 PM identified she was unsure what date the investigation was fully completed for the incident on 2/22/24, but that some of the witness statements for the investigation were obtained on 2/28/24.<br><br>Although attempted, an interview with the Administrator could not be obtained.<br><br>Review of the facility policy, Abuse/Resident dated 7/23/23, directs that abuse or mistreatment of any kind toward a resident is strictly prohibited and all allegations will be thoroughly investigated and acted upon. The policy further directs that the Administrator/DNS or designee will immediately conduct an investigation upon notification of an alleged allegation of abuse. Additionally, the policy directs that a description of the incident should be documented in the resident's nursing notes. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879<br><br>Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 4 sampled residents (Resident #30, Resident #65) reviewed for skin conditions, the facility failed to properly transcribe physician orders resulting in physician orders not being followed (Resident #30) and failed to follow physician's orders regarding Braden Scale Assessments and weekly body audits (Resident #65). Additionally, for the only sampled resident (Resident #71) reviewed for death, the facility failed to ensure that vital signs were taken per the physician orders. The findings include:<br><br>1. Resident #30 was admitted to the facility on [DATE] with diagnoses that included cellulitis of left lower limb, Methicillin Resistant Staphylococcus Aureus (MRSA), acute kidney failure, and edema.<br><br>A Nursing admission note dated 3/7/24 at 8:03 PM and written by RN #4 identified Resident #30 was alert, aware with confusion, had eschar open areas to bilateral lower extremities (BLE), with a treatment of Xeroform and clean dry dressing (CDD). The Nursing admission note and nurses notes failed to identify measurements of the wounds to Resident #30's BLEs.<br><br>A Resident Care Plan dated 3/7/23 identified Resident #30 had cellulitis, MRSA, chronic venous hypertension, ulcers to bilateral lower extremities, and was at risk for skin breakdown. Interventions included Braden scale completed upon admission and as per facility protocol, watch for increased pain, cramping, aching, and burning of extremities, watch for any signs infection is worsening, watch for fever chills, shaking, sweating, lethargy, dizziness, redness, changes in cognition and odor.<br><br>Physician orders dated 3/8/24 directed to cleanse Resident #30's bilateral shins with Normal Saline, gently wash with soap and water, and pat dry. Apply Xeroform gauze, cut to wound size, followed by non-adhesive, followed by a dry clean dressing, change every other day and as needed.<br><br>An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 had intact cognition and required partial/moderate assistance for eating, oral hygiene, and was dependent for toileting. Additionally, the MDS identified Resident #30 was substantial/ maximal assistance for showering, upper body dressing, and dependent for lower body dressing. The MDS further identified Resident #30 had 2 venous/arterial ulcers.<br><br>A progress note from the Wound Physician (MD #1) dated 3/18/24 directed new wound care orders to cleanse wound, apply Alginate, apply dry clean dressing, and to change daily and as needed for soiling, saturation, and accidental removal. MD #1's progress note further identified measurements of bilateral lower extremities as follows: Right lower extremity (RLE) 1.5 centimeters (cm) by 1.0 cm by 0.1 cm. The left lower extremity (LLE) measured 2 cm by 3.5 cm by 0.1 cm (Resident #30 was admitted on [DATE] with wounds, but wounds had not been measured until 3/18/24).<br><br>A progress note dated 3/25/24 at 11:14 PM from MD #1 directed treatment recommendations to cleanse with Normal Saline, apply Calcium Alginate to the base of the wound, secure with Super Absorbent Dressing (SAD), and to change daily and as needed for soiling, saturation, or accidental removal (this was a treatment change from 3/18/24). Measurements of the RLE were 1.5 cm by 1.0 cm by 0.1 cm and measurements of the LLE were 3.0 cm by 3.5 cm by 0.1 cm.<br><br>(continued on next page) |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A progress note dated 4/1/24 at 5:36 PM from MD #1 directed treatment recommendations to Resident #30's BLE to cleanse with Normal Saline, apply Calcium Alginate to the base of the wound, secure with Super Absorbent Dressing (SAD), and to change daily and as needed. Measurements of RLE were 1.5 cm by 1 cm by 0.1 cm and measurements of the LLE were 4.5 cm by 2.5 cm by 0.1 cm (a larger size than previously measured on 3/25/24).<br><br>Interview and review of the physician orders and Treatment Administration Record with the DNS on 4/2/24 at 9:10 AM identified that from 3/8/24 through 4/2/24, Resident #30 was receiving a treatment to his/her bilateral shins consisting of Normal Saline, gently wash with soap and water, and pat dry. Apply Xeroform gauze, cut to wound size, followed by non-adhesive, followed by a dry clean dressing despite MD #1's direction to change treatment orders to cleansing with Normal Saline, apply Calcium Alginate to the base of the wounds and securing with SAD on 3/18/24, 3/24/24 and 4/1/24.<br><br>Additionally, the DNS identified MD #1's wound orders were not transcribed on 3/18/24, 3/25/24 and 4/1/24, resulting in Resident #30 not receiving the appropriate wound treatment, and the clinical record failed to reflect any wound measurements upon admission until measured by MD #1 (10 days after admission). The DNS further identified that MD #1 sends her emails weekly with updated treatment orders but failed to distribute the new treatment orders for Resident #30 to the floor nurses and did not transcribe the new treatment orders.<br><br>Interview with MD #1 on 4/3/24 at 12:36 PM identified she communicates new orders to the DNS by email and was unaware the current treatment orders did not match her treatment order recommendations. MD #1 further identified she cannot state that Resident #30's LLE wound got worse due to incorrect wound treatment orders being followed as there could be many causes like diet change, not elevating legs and it was hard to say because venous stasis ulcers can be difficult to treat so it was hard to say which factors lead to Resident #30 LLE wound getting worse.<br><br>Per facility policy on physician orders, all orders are reviewed by the residents physician on next resident visit and covering physicians may give verbal/telephone orders.<br><br>2. Resident #65's diagnoses included a right tibia fracture, a history of falls, type 2 diabetes mellitus and chronic kidney disease.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was cognitively intact and required substantial assistance for bed mobility, was dependent for transfers, and required moderate assistance for personal hygiene. Additionally, the MDS identified that Resident #65 was at risk for developing pressure injuries and had Moisture Associated Skin Damage (MASD).<br><br>The Resident Care Plan (RCP) dated 2/6/24 identified Resident #65 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included completing the Braden Scale assessment upon admission and per facility protocol.<br><br>The RCP dated 2/6/24 identified Resident #65 had a right tibia fracture due to a fall. Interventions included following up with the orthopedic physician as recommended, rehab therapy as ordered to increase function and mobility, immobilizer in place as ordered, and the application and removal of the brace as ordered.<br><br>(continued on next page) |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | a. A physician's order dated 1/11/24 directed that a Braden Scale assessment was to be completed on admission and every week for 4 weeks.<br><br>Review of the clinical record identified that a Braden Scale assessment was completed on 1/10/24 in the Nursing Admission Assessment, indicating a mild risk of skin breakdown with a score of 16. There were no additional Braden Scale assessments identified in the clinical record.<br><br>b. A physician's order dated 1/11/24 directed that a body audit was to be completed on admission and every week by a licensed nurse on shower day and was to be documented on the body audit form.<br><br>Review of the clinical record identified that a body audit assessment was completed on 1/10/24 in the Nursing Admission Assessment, indicating 9 areas of skin abnormalities. There were no additional body audit assessments identified in the clinical record.<br><br>Interview and clinical record review with RN #3 on 4/1/24 at 11:43 AM identified that there were no additional Braden Scale assessments or body audits completed on Resident #65 after the 1/10/24 Nursing Admission Assessment. She indicated that these assessments should always be completed in the electronic health record under the assessments tab and these assessments were not completed on paper. Additionally, she identified that the 3:00 PM to 11:00 PM nurse was responsible to complete both the Braden Scale and skin assessments. The Braden Scale should have been completed weekly for 4 weeks following admission, and that skin assessments should have been completed for Resident #65 weekly on their shower day.<br><br>Review of the Braden Scale policy directed, in part, that all residents will have a Braden scale completed weekly for 4 weeks on admission and readmission to the facility, and then it will be completed annually, quarterly and upon a significant change in condition.<br><br>Review of the Body Audit policy directed, in part, that a licensed nurse will conduct a weekly body audit on the resident, preferably on the shower day, to identify any alterations in skin integrity. The body audit will be signed off by the nurse completing the audit on the Treatment Kardex and the weekly body audit form.<br><br>3. Resident #71's diagnoses included cerebrovascular accident (CVA), and dysphagia (difficulty swallowing).<br><br>The Nursing Admission assessment dated [DATE] identified Resident #71 was cognitively impaired, dependent on staff for eating and required the assistance of 2 staff for bed mobility and transfers.<br><br>a. An Advanced Practice Registered Nurse's (APRN) order dated 11/29/23 at 3:00 PM directed facility staff to administer the Influenza vaccine and to monitor Resident #71's temperature every shift for 48 hours.<br><br>A nurse's note dated 11/30/23 at 3:03 PM identified that the Infection Control Nurse (ICN) administered the Influenza vaccine to Resident #71.<br><br>Review of the clinical record from 11/30/23 through 12/3/23 failed to identify Resident #71's temperatures were taken following the vaccine.<br><br>(continued on next page) |

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| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

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|---|---|
| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | b. A nurse supervisor note (written by RN #7) dated 12/6/23 at 11:20 AM identified she had been notified that Resident #71 was hypoxic (low oxygen in body tissues). Further Resident #71 had a normal temperature, elevated heart rate of 110 beats per minute (normal range is 60-80), blood pressure of 122/68 (within normal range), and fine crackles in the bases of the lungs. RN #7 increased Resident #71's oxygen level to 4 liters per minute through a nasal cannula, the APRN was notified, and a new order for an immediate chest x-ray and vital signs every hour for 3 hours was ordered.<br><br>Review of Resident #71's clinical record on 12/6/23 failed to identify Resident #71's vital signs were monitored every hour for 3 hours on 12/6/23 as directed by the APRN following a change in condition.<br><br>In an interview with Regional Nurse (RN #5) on 4/3/24 at 1:30 PM, she indicated that the clinical record failed to show that Resident #71's temperatures from 11/30/23 through 12/3/23 and on 12/6/23 that vital signs were monitored as directed by the APRN. Although she was unable to explain the omission, RN #5 indicated that staff should follow APRN orders as directed.<br><br>50094<br><br>50250 |

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| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950<br><br>Based on clinical record review, review of facility policy, and interviews, for 2 of 3 sampled residents (Resident #31 and Resident #53) who had a pressure ulcer/injury, the facility failed to ensure Braden scales and body audits were completed per the facility's policy and the physician's orders (Resident #31), and failed to ensure a low air loss mattress was set at the appropriate setting for Resident #53's weight. The findings include:<br><br>1. Resident #31's was admitted on [DATE] with diagnoses including femur fracture (left thigh bone), peripheral vascular disease (poor circulation in lower extremities), and heart failure.<br><br>The Nursing Admission assessment dated [DATE] identified Resident #31 was alert and confused and required 1-2 people for assistance with bed mobility and transfers. Additionally Resident #31's skin was noted to be intact and a Braden scale identified that Resident #31 was at mild risk to develop a pressure ulcer.<br><br>The admission physician's order dated 3/2/24 directed a licensed nurse to complete a pressure ulcer prediction scale (Braden scale) weekly for four weeks, and to perform weekly skin inspections (skin assessments).<br><br>The Resident Care Plan dated 3/4/24 identified that Resident #31 was at risk for skin breakdown. Interventions included to keep his/her heels off the bed, to turn and reposition, and to check skin for signs of breakdown.<br><br>Review of the clinical record dated 3/2/24 through 3/31/24 identified a Braden scale was completed on 3/2/24 and a skin assessment was conducted on 3/6/24 and Resident #31's skin was intact. Review of the Medication Administration Record (MAR) identified skin assessments were due for completion every Wednesday, on 3/13, 3/20, and 3/27/24, and that Braden scales were due every Saturday on 3/9/, 3/16, and 3/23/24. Although the assessments were signed off as complete by the licensed staff on the MAR, review of the clinical record failed to identify documented skin assessments and/or Braden scales for the assigned dates.<br><br>Review of the nurse's note dated 3/12/24 at 2:39 PM documented that Resident #31's heels were found to be discolored. The right heel had a darkened area that measured 1 cm x 1.5 cm and the left heel had a darkened area that measured 2.3 cm x 2.0 cm with redness surrounding the area. Review of the clinical record failed to identify that a Braden scale had been documented following the discovery of the new pressure ulcer.<br><br>A physician's note dated 3/18/24 identified both heel discolorations were classified as pressure ulcers.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An interview and review of the clinical record on 4/3/24 at 8:46 AM with RN #4, identified although the skin assessments and Braden scales on the MAR had been signed by the licensed staff on the corresponding dates, the clinical record failed to indicate that the 3 scheduled skin assessments and the 3 scheduled Braden scales had been completed. Additionally, the clinical record failed to indicate that following the onset of Resident #31's facility acquired pressure ulcers to both heels, a change in condition Braden scale had not been completed. While RN #4 indicated that documentation may have been completed for the missing skin assessments and Braden scales and left in a different location, RN #4 was subsequently unable to locate the documentation in any of the areas that the documents would have been stored.<br><br>An interview and review of the clinical record with the DNS on 4/3/24 at 8:54 AM, identified that although Resident #31's clinical record contained 1 Braden scale (dated 3/2/24) and 2 skin assessments (3/2/24 and 3/6/24) the clinical record lacked any further documentation of skin assessments or Braden scales (paper or electronic). Further, the DNS indicated that the facility policy directed, after the onset of a pressure ulcer, an additional Braden scale should have been completed. Although a review of the MAR with the DNS identified that the licensed staff had signed the skin assessments and Braden scales as completed, she was unable to explain the lack of documented skin assessments and Braden scales in the medical record, but if the licensed staff signed the MAR, then the documentation should have been present.<br><br>Review of the Wound and Skin Care protocols directed, in part, for a licensed nurse to complete a body audit each week.<br><br>Review of the Braden Scale policy directed, in part, for a licensed nurse to complete a resident's Braden scale each week for four weeks on admission to the facility and upon a significant change in the resident's condition.<br><br>2. Resident #53's diagnosis included cerebral vascular accident, dementia, and mitral valve insufficiency.<br><br>A Braden Scale (a tool used for identifying a residents risk for the development of pressure ulcers) dated 3/5/24 scored Resident #53 at a moderate risk for developing a pressure injury.<br><br>The quarterly Minimum Date Set (MDS) assessment dated [DATE] identified Resident #53 was moderately cognitively impaired, required a mechanical lift, was totally dependent with assist of 2 for transfers and toilet use, required an extensive assist of 2 for bed mobility, and was independent with set up for eating. The MDS also identified Resident #53 was at risk for developing a pressure ulcer.<br><br>A progress note from the Wound Physician and dated 3/18/24, identified Resident #53 was seen and was found to have a Stage 2 pressure ulcer to left buttocks, a Stage 3 pressure ulcer to the coccyx and a low air loss mattress was ordered.<br><br>The Resident Care Plan dated 3/19/24 identified Resident #53 was at risk for skin breakdown due to decreased mobility, and incontinence. Other risk factors may be poor nutrition, poor circulation, pronounced body prominences, poor circulation, altered sensation, and mechanical forces. Interventions included a low air loss mattress to the bed and check function every shift.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab Cromwell | 156 Berlin Road<br>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.

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|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the clinical record for weights identified that Resident #53's weight on 3/18/24 was 155 pounds.<br><br>The Treatment Administration Record (TAR) for March 2024 directed a low air mattress to the bed and to check function every shift. LPN #2 had initialed the TAR on 3/22/24, 3/23/24, 3/27/24, 3/28/24, and 3/29/24 that the low air mattress was on the bed and function checked.<br><br>Observation and interview on 4/1/24 at 11:10 AM with the Wound Physician identified that the air mattress was set to 325, as per the Wound Physician this setting should be according to the resident's weight (which was 155 pounds on 3/18/24). The Wound Physician stated setting of the low air loss mattress could influence the healing depending on how long the low air loss mattress had been set like that (325). Additionally, the Wound Physician stated a setting of too firm would not be beneficial for wound healing.<br><br>Interview and observation on 4/1/24 at 11:36 AM with LPN #2 identified she was unsure on how to set the low air loss mattress and had never been trained on setting the low air loss mattress.<br><br>Interview on 4/1/24 at 12:27 PM with the Dietician identified that Resident #53's weight was currently 153 pounds.<br><br>Interview with the DNS on 4/1/24 at 1:11 PM identified that the setting of the low air loss mattress was set by the resident's weight and that the Charge Nurse on the unit was responsible for setting and checking the function of the low air loss mattress each shift. She also stated that the training for this function would take place during the orientation process.<br><br>Subsequent to surveyor inquiry, the low air loss mattress setting was adjusted to reflect Resident #53 weight of 153 pounds and set correctly by LPN #2.<br><br>50095 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250<br><br>Based on observation, clinical record review, review of facility policy, and interview for the only sampled resident (Resident #71) reviewed for a death record, the facility failed to ensure that liquids were not accessible to a resident who was on aspiration (choking) precautions. The findings include:<br><br>Resident #71's diagnoses included cerebrovascular accident (stroke) with left sided paralysis, Barrett's esophagus (narrowed esophagus), and dysphagia (difficulty swallowing).<br><br>The Nursing Admission assessment dated [DATE] identified Resident #71 was cognitively impaired, dependent on staff for eating, and required the assistance of 2 staff for bed mobility and transfers.<br><br>The Resident Care Plan (RCP) dated 11/29/23 identified Resident #71 was at risk for aspiration (food or fluids going into the lungs) with interventions that included assisting with feeding, watching for signs/symptoms of aspiration, alternating solids and liquids, encouraging small sips of fluid and small bites of food, encouraging the resident to remain in an upright position, at 90 degrees, for all intake, and to remain upright for 30 minutes to 1 hour after eating.<br><br>The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #71 was severely cognitively impaired, required maximum assistance with eating, and was dependent for oral hygiene. Additionally, Resident #71 experienced loss of liquids and solids from his/her mouth when eating or drinking, held food in their mouth, coughed or choked during meals, and required a mechanically altered diet of pureed food with thickened liquids.<br><br>A physician's order dated 12/1/23 directed 1 to 1 supervision for Resident #71 with feeding/eating, and that his/her diet was to be puree textured food, honey thickened liquid consistency, and that Resident #71 required aspiration precautions.<br><br>A nurse's note (written by RN #6) dated 12/6/23 at 2:39 PM identified Resident #71 had consumed fluid at the bed side and was seen by another staff coughing. Resident #71 was assessed, s/he was afebrile (without fever), his/her oxygen saturation (blood oxygen level) was 68% (normal range is 90% to 100%), and the remainder of the residents vital signs were stable. Oxygen was applied, the Advanced Practice Registered Nurse (APRN) was notified, and a chest x-ray was ordered.<br><br>Review of Person #2's written report dated 12/7/23 at 11:39 AM identified on 12/6/23 s/he was on a facetime call with Resident #71 and noted that the resident appeared different. Person #2 indicated that while s/he was asking Resident #71's visitor about Resident #71's condition, a male nurse came in and told him/her (Person #2) that a cup of water had been left within Resident #71's reach, the resident had chugged the liquid and aspirated, and was then placed on oxygen. The written report from Person #2 further identified that Resident #71 was recovering from a stroke and required 1 to 1 assistance with feeding prior to this incident.<br><br>(continued on next page) |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A nurse supervisor note (written by RN #7) dated 12/6/23 at 11:20 AM identified she had been notified that Resident #71 was hypoxic (low oxygen in body tissues). RN #7 indicated Resident #71 had a normal temperature, an elevated heart rate of 110 beats per minute (normal range 60-80), blood pressure of 122/68 (within normal range), and fine crackles in bases of the lungs upon auscultation (listening). RN #7 increased Resident #71's oxygen level to 4 liters per minute through a nasal cannula (tubing). The APRN was notified and directed an immediate chest x-ray and vital signs every hour for 3 hours.<br><br>A Speech Language Pathologist (SLP) note dated 12/6/23 at 4:57 PM identified that she was asked to see Resident #71 after the resident was found by Physical Therapy (PT) and Occupational Therapy (OT) trying to drink by his/herself which resulted in Resident #71 coughing and having chest congestion. RN #6 was notified immediately. The SLP note further indicated that she encouraged Resident #71 to perform strong coughs, however Resident #71 had difficulty following directions. The SLP attempted to facilitate swallowing with downward lingual pressure (tongue pressure) using an empty spoon, however this was not effective. The SLP subsequently educated staff not to leave food or drink within Resident #71's reach due to his/her required 1 to 1 supervision with food and eating assistance. The SLP noted that Resident #71 was attempting to self-feed, however s/he was not safe to self-feed and that RN #6 then resumed care.<br><br>An APRN note dated 12/7/23 at 2:51 PM identified Resident #71 was transferred to the hospital with diagnoses of aspiration pneumonia, leukocytosis (elevated white cell count), and acute kidney injury (AKI) due to Resident #71's inability to meet fluid goals, poor oral intake, and an increased oxygen demand.<br><br>A hospital discharge summary dated 1/9/24 identified Resident #71 was admitted to the hospital's Intermediate Care Unit (IMCU) and required high flow oxygen treatment due acute respiratory failure with hypoxia, aspiration pneumonia of the left lower lobe, and pneumonia due to the COVID-19 virus which had been diagnosed upon arrival to the hospital (12/7/23). Resident #71 had a Percutaneous endoscopic gastrostomy tube (PEG Tube/feeding tube) placed due to severe dysphagia, had a non-ST elevation myocardial infarction (heart attack), and required close telemetry monitoring (heart monitoring). Additionally, it was noted that Resident # 71's hospital stay was complicated by aspiration pneumonia.<br><br>Interview with RN #6 on 4/9/24 at 12:28 PM, who responded to the incident on 12/6/23, identified that PT notified him that she saw Resident #71 guzzle water from a cup and began to cough. RN #6 ran to Resident #71's room, obtained vital signs, and started Resident #71 on oxygen due to the low oxygen saturation levels. RN #6 was unable to recall the actual oxygen saturation level stating he thought it was 58% or 68%. RN #6 notified both the nursing supervisor and the APRN of the incident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Interview with the SLP on 4/9/24 at 1:26 PM indicated that PT #3 and COTA #1 were walking by Resident #71's room and that from the hallway they observed Resident #71 in bed, alone, in the upright position, with a cup in his/her hand. PT #3/COTA #1 reported that Resident #71 had consumed the fluid, was coughing, and had spilled some liquid on his/her clothing. Additionally, Resident #71 was noted to be congested when breathing and that she was asked to evaluate the resident. The SLP stated that she had tried to get Resident #71 to clear his/her airway by swallowing, but her attempts had been ineffective. The SLP identified that the hospital discharge summary, on Resident #71's arrival to the facility, indicated that Resident #71 required 1 to 1 supervision with meals and that this was continued at the facility on Resident #71's admission orders due to his/her risk for aspiration. Subsequent to assessing Resident #71 after the 12/6/23 incident, the SLP instituted orders for feeding in a few places, not to leave a tray or fluids at the bedside, and to continue the 1 to 1 supervision.<br><br>Interview with the Occupational Therapy Assistant (COTA #1) on 4/9/24 at 1:57 PM identified that she had helped to reposition and bathe Resident #71 after the resident was noted to have consumed the liquid. COTA #1 noted that the front of Resident #71's [NAME] had been soaked with a thickened liquid. COTA #1 indicated that Resident #71 was not aware that s/he had a deficit following the stroke and lacked initiation and self-awareness. Additionally, COTA #1 identified that she saw liquids and/or food left at bedside, across the room previously and did not believe Resident #71 had the ability to reach over.<br><br>Interview with PT #3 on 4/9/24 at 2:30 PM identified that on 12/6/23 she had seen Resident #71 from the hallway, in bed, upright, and that the resident was holding a cup in his/her hand. PT #3 noted that Resident #71 was found with fluid down the front of his/her [NAME], and she notified the SLP. PT #3 stated that Resident #71 had a dense stroke, was flaccid on the left side, and had a right sided gaze. PT #3 indicated that Resident #71 was on aspiration precautions, required assistance with eating and drinking and required cues to swallow. Further, PT #3 identified that she had not seen Resident #71 with any visitors in the morning, on the day she discovered him/her holding the cup, only staff were present and upon discovery Resident #71 had been alone in the room with the cup in his/her hand.<br><br>Interview and observation with Nurse Aide (NA) #4 on 4/9/24 at 3:04 PM identified that she assisted feeding Resident #71 with breakfast on 12/6/23. An observation of Resident #71's previous room identified that the overbed table was on the left side of the bed (as it was currently located) adjacent to the bed with the corner of the overbed table (approximately 6 inches) overlapping the mattress and touching Resident #71's half side rail (as it was currently positioned). Additionally, NA #4 identified that Resident #71 had been sitting upright following breakfast. NA #4 identified she had left Resident #71's thickened drink to the left of Resident #71 thinking that it would be out of his/her reach. NA #4 indicated that Resident #71 did not have visitors in his/her room around the time of and following breakfast, that only staff were present, that dietary staff had passed out the meal and that NA were responsible to distribute fluids.<br><br>Interview with PT #3, COTA #1 and the SLP on 4/9/24 at 3:17 PM identified that it was unlikely but not impossible for Resident # 71 to reach over to his/her left side while in the upright position and pick up a cup if it had been located on the overbed table (where NA #4 indicated the overbed table had been located and where she had left the resident's beverage).<br><br>Attempts to reach RN #7 and Person #2 were unsuccessful.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the facility Dysphagia policy identified, in part, that residents with dysphagia have difficulty swallowing liquids and/or solids that might pose a safety issue/risk for aspiration. Aspiration precautions may be instituted on residents who have dysphagia, and who have orders from a physician, nurse, or speech/language pathologist. Further, the Dysphagia policy procedure indicated that aspiration precautions included the head of the bed be elevated to a minimum of 30 degrees, supervision of meals may be identified, and positioning needs may be assessed. Interventions would be resident specific. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950<br><br>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #53) reviewed for nutrition, the facility failed to ensure that a monthly weight and reweight was obtained after a significant weight loss. The findings include:<br><br>Resident #53's diagnoses included cerebral vascular accident, dementia, and mitral valve insufficiency.<br><br>Review of the Weights and Vitals Summary identified Resident #53 was weighed on 9/15/23 with a weight of 174.9 pounds and not reweighed again until 1/4/24 with a weight of 176.5 pounds. Resident #53 was not weighed in February 2024.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 was moderately cognitively impaired, required a mechanical lift, and was totally dependent with assist of 2 for transfers and toileting. Additionally, the MDS identified Resident #53 was extensive assist of 2 for bed mobility and was independent with set up for eating.<br><br>Review of the Weights and Vitals Summary identified on 3/18/24, Resident #53 weighed 155 pounds which was a 21.5 pound (lb) or 12.1% loss in 74 days (since the previous weight of 176.5 lbs on 1/4/24).<br><br>Interview with the Dietician on 4/1/24 at 12:27 PM identified that she requested a reweight after it was identified Resident #53 had a weight loss on 3/18/24 by placing a paper on the Charge Nurses medication cart and was still waiting for a reweight of Resident #53. The Dietician stated that she would expect a reweight the same day or the next day and indicated the policy stated that a reweight must be obtained if there was a gain or loss of 5 pounds.<br><br>Interview with the Director of Nurses (DNS) on 4/1/24 at 1:20 PM identified that she would expect a reweight within 24 hours and that Resident #53 was to be weighed every month. The DNS also identified that the weight from February was not completed, and Resident #53 had not been reweighed since 3/18/24 which identified a significant weight loss.<br><br>Interview with LPN #2 on 4/2/24 at 9:59 AM stated that the Nurse Aides (NA) document the resident's weight in the electronic medical record and the residents were usually weighed on their shower day or if the Dietician requested a reweight. She further identified the Dietician requests a reweight by bringing a list to the nursing station. She further identified sometimes it takes time for the NAs to get the weights completed.<br><br>Facility policy for Weight Monitoring stated that accurate and timely measurement of weight changes in all residents is an important tool in assessing their nutritional status. Residents will be weighed weekly for 4 weeks on admission and readmission then monthly, unless otherwise indicated by the MD order and/or recommendation by the Registered Dietician. It is the responsibility of the Charge Nurse to assure that weights are taken. If there is a 5% weight discrepancy (plus or minus) a reweighed should be obtained.<br><br>(continued on next page) |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Subsequent to surveyor inquiry, Resident #53 was weighed on 4/1/24 identified a weight of 153 lbs or a 2 lb loss since 3/18/24 and a 23.5 lb/13.3% loss in 87 days. The Dietician subsequently recommended weekly weights for 4 weeks and 30 milliliters of Liquid Protein, two times a day. |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950<br><br>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 sampled resident (Resident #61) reviewed for respiratory therapy, the facility failed to administer oxygen at the correct setting, per physician orders. The findings include:<br><br>Resident #61's diagnoses included acute respiratory failure with hypoxia, Covid-19, and hypertension.<br><br>A physician's order dated 1/11/24 directed oxygen at 2 liters (L) continuously, to maintain oxygen saturation greater than 90% every shift, for shortness of breath.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was moderately cognitively impaired, was a total mechanical lift with assist of 2, extensive assistance of 1 with eating, extensive assist of 2 for bed mobility, and was dependent with assist of 2 for toileting. Also, the MDS identified that Resident #61 utilized oxygen.<br><br>Observation on 3/27/24 at 12:23 PM and on 3/28/24 at 9:30 AM identified Resident #61 had a nasal cannula in place, which was connected to portable oxygen which was set at 3 liters (despite a physician order to set at 2 liters).<br><br>The Treatment Administration Record identified that LPN #2 had already checked the oxygen administration level on 3/27/23 and that it was set at 2 liters.<br><br>Interview and observation with LPN #2 on 3/28/24 at 11:32 AM identified that the oxygen was incorrectly set at 3 liters and was not set by her that morning as she was busy with medication pass. LPN #2 stated that Nurse Aide (NA) #1 provided care to Resident #61 and placed the oxygen on the resident.<br><br>Interview on 3/28/24 at 11:08 AM with NA #1 identified that she provided morning care to Resident #61 and that she applied the portable oxygen on the resident. NA #1 also identified that she set the oxygen at 3 liters and was unsure of what the physician order was. NA #1 did not realize that applying and setting oxygen for residents was not within her scope of practice as a NA.<br><br>Interview with the Director of Nursing (DNS) on 4/1/24 at 1:17 PM identified that only licensed staff were to set the level of oxygen for residents and that a NA should not be performing that task.<br><br>Subsequent to surveyor inquiry, LPN #2 adjusted the oxygen to the correct physician order of 2 liters.<br><br>50250 |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950<br><br>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 sampled residents (Resident #53) reviewed for pressure ulcers, the facility failed to ensure LPN #2 was trained on the setting of a low air loss mattress. The findings include:<br><br>Record review of training for LPN #2 showed date of hire 3/8/22 and could not identify training on a low air loss mattress.<br><br>Resident #53's diagnoses included a cerebral vascular accident, dementia, and mitral valve insufficiency.<br><br>The quarterly Minimum Date Set (MDS) assessment dated [DATE] identified Resident #53 was moderately cognitively impaired, required a mechanical lift, was totally dependent with assist of 2 for transfers and toilet use, required an extensive assist of 2 for bed mobility, and was independent with set up for eating. The MDS also identified Resident #53 was at risk for developing a pressure ulcer.<br><br>A progress note from the Wound Physician and dated 3/18/24, identified Resident #53 was seen and was found to have a Stage 2 pressure ulcer to left buttocks, a Stage 3 pressure ulcer to the coccyx and a low air loss mattress was ordered.<br><br>The Resident Care Plan dated 3/19/24 identified Resident #53 was at risk for skin breakdown due to decreased mobility, and incontinence. Other risk factors may be poor nutrition, poor circulation, pronounced body prominences, poor circulation, altered sensation, and mechanical forces. Interventions included a low air loss mattress to the bed and check function every shift.<br><br>Review of the clinical record for weights identified that Resident #53's weight on 3/18/24 was 155 pounds.<br><br>The Treatment Administration Record (TAR) for March 2024 directed a low air loss mattress to the bed and to check function every shift. LPN #2 had initialed the TAR on 3/22/24, 3/23/24, 3/27/24, 3/28/24, and 3/29/24 that the low air mattress was on the bed and function checked.<br><br>Observation and interview on 4/1/24 at 11:10 AM with the Wound Physician identified that the air mattress was set to 325, as per the Wound Physician this setting should be according to the resident's weight (which was 155 pounds on 3/18/24). The Wound Physician stated setting of the low air loss mattress could influence the healing depending on how long the low air loss mattress had been set like that (325). Additionally, the Wound Physician stated a setting of too firm would not be beneficial for wound healing.<br><br>(continued on next page) |

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|---|---|---|---|
| | 075380 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab Cromwell | 156 Berlin Road<br>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.

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Observation of Resident #53 and interview on 4/1/24 at 11:36 AM with LPN #2 identified that Resident #53 was lying in bed with the low air loss mattress set at 325. LPN #2 noted being unsure of how to set the low air mattress correctly asking the surveyor how to change the setting. LPN #2 further identified that the facility had numerous different kinds of air mattress' and it was confusing on how to set the air mattress. LP#2 stated that she had never received training on setting the air mattress and she reached out to maintenance because she thought he would know how to perform this task.<br><br>Interview on 4/1/24 at 12:27 PM with the Dietician identified that Resident #53's weight was currently 153 pounds.<br><br>Interview with the Director of Nursing (DNS) on 4/1/24 at 1:11 PM identified that the setting of the air mattress was set by the resident's weight and that the Charge Nurse on the unit was responsible for setting and checking the function of the low air loss mattress each shift. She also stated that the training for this function would take place during the orientation process.<br><br>Subsequent to surveyor inquiry the air mattress setting was adjusted to reflect Resident #53's weight of 153 pounds. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50249<br><br>Based on observations, interviews and review of the facility policy related to medication storage, the facility failed to properly secure a controlled substance and properly secure a medication storage room. The findings include:<br><br>a. Interview and observation of the East medication storage room with LPN #2 on 4/2/24 at 2:30 PM identified that the controlled drug box inside of the refrigerator was unlocked and found to contain one 30 milliliter (ml) unopened bottle of Lorazepam (a schedule 4 controlled substance) 2 milligram (mg)/ml inside. An additional padlock was observed outside of the refrigerator door which was also found to be unlocked/not engaged. LPN #2 stated she was aware that the controlled drug box inside of the refrigerator had a broken lock and could not be secured. LPN #2 further identified that she had notified the Maintenance Department and the DNS but that it had not been repaired or replaced yet. Additionally, LPN #2 stated she was aware the lock outside of the refrigerator should have been secured and that she thought it was locked.<br><br>Interview with the Director of Maintenance on 4/3/24 at 9:45 AM identified that he was not aware that the East medication storage room controlled drug box inside of the refrigerator had a broken lock and could not be secured. The Director of Maintenance further identified that he did not receive a maintenance request for the broken lock and that nursing staff should have put in a maintenance request when the broken lock was first observed.<br><br>Interview with the DNS on 4/3/24 at 10:00 AM identified that she was not aware that the East medication storage room controlled drug box inside of the refrigerator had a broken lock and could not be secured. The DNS further identified that nursing staff should have put in a maintenance request when the broken lock was first observed.<br><br>Review of the Facility Work Request Log/East for 2/21/24 through 3/31/24, failed to identify that the broken lock on the East medication storage room refrigerator controlled drug box was documented in the log for maintenance to address.<br><br>Review of facility Storage and Expiration Dating of Medications, Biologicals policy, dated January 2022, identified that Controlled Substances stored in the refrigerator must be in a separate container and double locked.<br><br>(continued on next page) |

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| Apple Rehab Cromwell | 156 Berlin Road<br>Cromwell, CT 06416 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | b. On 4/3/24 at 9:50 AM, while conducting an observation with the Director of Maintenance of the East medication storage room's refrigerator, the East medication storage room door was observed to be unsecured and propped open with a garbage can. Additionally, and within close proximity of the unsecured East medication storage room, three visitors were observed in a resident's room and four residents were observed sitting in wheelchairs in the proximity to the medication room. There were no other identifiable facility staff observed in the area at this time. At 9:52 AM, LPN #3 was observed exiting from a resident's room which was at the far end of the East hallway. LPN #3 then walked to the nurse's station, outside of the East medication storage room, and stated that she had propped the door open because she had a resident remove a dressing and she had to get into the room quickly to obtain supplies and that she was not gone long.<br><br>Interview with the DNS on 4/3/24 at 10:00 AM identified that the East medication storage room should have been secured and not propped open with a garbage can. The DNS stated she would address the issue further with LPN #3.<br><br>Review of facility Storage and Expiration Dating of Medications, Biologicals policy, dated January 2022, identified the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879<br><br>Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 1 of 4 residents (Resident #65) reviewed for skin conditions, the facility failed to include and have available consultations from outside vendors available in the paper or electronic chart. The findings include:<br><br>Resident #65's diagnoses included a right tibia fracture, history of falls, type 2 diabetes mellitus, and chronic kidney disease.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was cognitively intact and required substantial assistance for bed mobility, was dependent for transfers, and required moderate assistance for personal hygiene.<br><br>The Resident Care Plan dated 2/6/24 identified Resident #65 had a right tibia fracture due to a fall. Interventions included following up with the orthopedic physician as recommended/ scheduled, immobilizer in place as ordered, applying and removing the brace as ordered, and rehab therapy as ordered to increase function and mobility.<br><br>Review of the clinical record failed to identify any consultant documentation or notes from the orthopedic provider which Resident #65 had seen.<br><br>Interview with RN #5 on 4/3/24 at 10:04 AM identified that orthopedic consults aren't filed in the chart and that therapy staff keeps them in the filing cabinets in the Rehabilitation room. Additionally, she indicated that the orthopedic consult sheets are not scanned into the electronic health record.<br><br>Subsequent to surveyor inquiry, the facility provided orthopedic consult documentation from therapy staff indicating that Resident #65 had outside orthopedic appointments on 1/26/24, 2/9/24, 2/16/24, and 3/27/24.<br><br>Interview with PT #1 on 4/3/24 at 10:16 AM identified that she locks the doors to the Rehabilitation room each day when she leaves. She indicated that there used to be a key on the Nursing Supervisor keys to gain access into the room on off hours, but from her understanding the key was removed and the staff no longer have access. She reported that for as long as she could remember, therapy had always kept the consult sheets in their filing cabinets.<br><br>Interview with RN #4 on 4/3/24 at 10:19 AM identified that she does not have a key on her supervisor keys to get into the Rehabilitation room, and that staff cannot access it after hours, as it was locked. She reported that when a resident returns to the facility from an outside appointment, the floor nurse or nurse supervisor review the consult, call the physician if necessary, write a note in the resident's chart, and then give the consult sheet to therapy. If the staff had any questions about the consult after therapy had left for the day, they don't have a copy of the consult to cross reference, nor was it uploaded into the electronic health record.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Although requested, a facility policy for outside vendor consultations was not provided. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879<br><br>Based on observation, interviews, and facility policy for Resident #22 and Resident #65, the facility failed to follow infection control practices on 1 of 3 units to provide a clean environment, by improperly storing disposable medical equipment. During a tour of the laundry area, the facility failed to ensure a clean environment for laundry and for 1 of 4 residents reviewed for pressure ulcers, the facility failed to use appropriate hand hygiene and personal protective equipment (PPE) when providing wound care. The findings include:<br><br>1. Resident #22's diagnoses included a right femur fracture, history of falling, and muscle weakness.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #22 was cognitively intact and required moderate assistance with bed mobility and was dependent with transfers and toileting.<br><br>2. Resident #65's diagnoses included a right tibia fracture, history of falls, and muscle weakness.<br><br>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was cognitively intact and required substantial assistance for bed mobility and was dependent for transfers and toileting.<br><br>The Resident Care Plan dated 2/5/24 identified Resident #65 required staff assistance with activities of daily living. Interventions included assisting as needed to meet toileting needs and providing incontinence care.<br><br>Observation on 4/1/24 at 10:17 AM identified 2 uncovered bedpans tucked in the handrail behind the toilet in the shared bathroom of Residents #22 and #65.<br><br>Observation on 4/1/24 at 11:12 AM identified 2 uncovered bedpans tucked in the handrail behind the toilet, after the Housekeeper had cleaned Residents #22 and #65's room.<br><br>Interview with Residents #22 and Resident #65 on 4/1/24 at 2:01 PM identified that each of their personal bedpans were stored in the bathroom behind the toilet after use, and not covered and placed in their individual side table or dresser.<br><br>Interview and observation with the DNS on 4/1/24 at 2:56 PM identified 2 bed pans uncovered, stored in the handrail behind the toilet in the shared bathroom of Residents #22 and #65. She further identified that the bedpans were labeled A and B but were not covered or stored appropriately. The DNS indicated they should have been stored covered, in separate bags and stored in the bathroom safety bar handrail. The DNS indicated she was unsure of the reason the bedpans had been stored improperly.<br><br>Review of the Bedpan, Giving and Removing policy directed, in part, to store the bedpan in resident's bedside dresser or store labeled bedpan in plastic bag in bathroom (ensuring the items were not on the floor)<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 3. Observation in the laundry room on 4/3/24 at 9:03 AM identified the following:<br><br>a. A moderate coating of white/gray debris on the guard of a wall-mounted fan blowing directly onto clean laundry located on the folding table.<br><br>b. A moderate coating of white/gray debris on both sides of the ceiling fan's paddles were above where the clean laundry is transferred out of the dryer.<br><br>c. A moderate coating of white/gray debris on the pre-dispensing chemical boxes and tubing that mix and dispense the laundry chemicals.<br><br>d. A significant amount of white/gray debris on the dryer tops.<br><br>Interview with Laundry Supervisor #1 and Laundry Attendant #2 on 4/3/24 at 9:03 AM identified that laundry staff were responsible for daily cleaning of the floors, weekly cleaning of laundry pre-dispensing chemical boxes and tubing, and monthly cleaning of the walls. Laundry or maintenance staff are responsible for cleaning the fans every 3 days. Laundry Supervisor #1 stated she was not aware of the gray/white debris coating the fans, the pre-dispensing chemical boxes and tubing, or the dryers, but the areas needed to be cleaned and she would notify maintenance.<br><br>Interview with Maintenance Supervisor #1 on 4/3/24 at 9:10 AM identified that maintenance staff were responsible for the monthly cleaning of the dryer tops and the lint containers. The Maintenance Supervisor #1 stated he was unaware of the significant buildup of white/gray debris on the dryer tops.<br><br>The March 2024 Laundry Room Cleaning Schedule listed cleaning responsibilities, and each task was documented as completed. Additionally, all cleaning logs for 2023 through present were reviewed and noted to be completed with staff signatures.<br><br>4. Resident #44's diagnoses included dementia with behavioral disturbance, psychotic disorder with delusions, and adjustment disorder with anxiety.<br><br>The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #44 was severely cognitively impaired and required moderate assistance with eating, total assistance with transfer, toileting, dressing, and was non ambulatory.<br><br>The Resident Care Plan dated 2/26/24 identified a deep tissue injury to the coccyx that was unstageable. Interventions included weekly wound physician visits as needed, treatments as ordered, and observing wounds for further deterioration, infection, and pain. Additionally, interventions also included to encourage/assist the resident to reposition side to side when in bed, and use an air mattress, checking the function and setting every shift.<br><br>A physician's order dated 3/6/24 directed to apply Alginate and cover the wound with a bordered foam dressing daily, and as needed for soiling, saturation, or accidental removal.<br><br>Observation on 4/1/24 at 11:44 AM identified LPN #2 removed the soiled coccyx dressing and cleansed the wound without changing her gloves or performing hand hygiene before applying the clean dressing on the wound.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Interview with the Director of Nursing Services (DNS) on 4/1/24 at 12:00 PM identified that LPN #1 should have changed her gloves and performed hand hygiene after removing the soiled dressing and before applying the clean dressing on the wound. The DNS indicated education would be conducted with LPN #2.<br><br>Review of the dry, clean dressing policy, in part, indicates to loosen tape, remove soiled dressing, remove gloves, wash or sanitize hands with hand sanitizer, and apply gloves.<br><br>50059<br><br>50179 |