STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075388	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Avon	220 Scoville Road Avon, CT 06001

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for wound care, the facility failed to ensure the record was complete and accurate to include a verbal treatment order and failed to include timely documentation of wound care provided. The findings include:Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for wound care, the facility failed to ensure the record was complete and accurate to include a verbal treatment order and failed to include timely documentation of wound care provided. The findings include: Resident #1's diagnoses included panniculectomy (removal of excess fat/skin in lower abdomen) during 2024, infection following surgical procedure and wound dehiscence (reopened). Physician order dated 7/7/2025 directed to change wound vac dressing three (3) times per week on Monday, Wednesday and Friday. The Resident Care Plan (RCP) dated 7/7/2025 identified Resident #1 was at risk for skin breakdown and had a wound vac to the lower back related to a surgical wound dehiscence (reopened). Interventions directed to provide wound care as ordered and notify wound specialists as ordered/needed. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being cognitively intact, and had a surgical wound. Review of the MAR/TAR (medication administration/treatment administration record) dated 7/21/2025 identified RN #1 had documented wound treatment as hold/held and see nursing progress notes. A nursing note dated 7/21/2025 at 3:16 PM by RN #1 identified wound vac dressing change was on hold, and an alternate dressing was applied until wound vac machine is replaced. Order was placed and estimated to arrive today. Review of the physician orders failed to identify an order for an alternative dressing in replacement of the wound vac on 7/21/2025 through 7/23/2025. Interview and clinical record review with RN #1 on 8/25/2025 at 12:10 PM identified Resident #1's wound vac had stopped working on 7/21/2025 and RN #1 had notified the DON #2 to order a new wound vac. RN #1 stated he had notified APRN #1 regarding the issue and received a verbal order to place a wet to dry dressing until the new wound vac was delivered to the facility. RN #1 was unable to provide documentation that the verbal order was placed in the electronic medical record (EMR) but indicated he should have entered the order in the record. RN #1 stated he must have forgotten to document in the EMR. Interview with APRN #1 on 8/25/2025 at 12:25 PM identified RN #1 notified her that Resident #1's wound vac had stopped working. APRN #1 gave a verbal order for a wet to dry wound dressing (treatment) until the new wound vac was received, for Resident #1's wound and to follow-up with APRN #2 accordingly if there were any other changes noted. APRN #1 identified verbal orders should be placed in the EMR. Review of the facility undated Physician Orders Policy directed in part, written and/or verbal orders may be obtained. When taking verbal/telephone orders write down the complete order and read-back to verify. Verbal/telephone orders must have the abbreviation T.O. documented followed by the provider's name and credential and authorized person receiving the order (i.e., T.O. Dr. Brown/J. [NAME], RN). Review of the facility undated Nursing Documentation Policy directed in part, documentation should be completed as soon as possible after care is provided, assessments are conducted, or any significant event occurs, ideally within the same shift.