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	11/25/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, review of facility documentation, facility policy and interviews for bi-monthly narcotic audits, the facility failed to maintain and keep records of bi-monthly narcotic audits. The findings include: Based on observation, review of facility documentation, facility policy and interviews for bi-monthly narcotic audits, the facility failed to maintain and keep records of bi-monthly narcotic audits. The findings include: During the onsite review of the medication storage room on 9/25/25 at 12:29 PM, the most recent documented bi-monthly narcotic audit log was dated September 1, 2025. Observation of the bi-monthly narcotic audit logs identified the months for April 2025, May 2025, June 2025, July 2025, and August 2025 were not available. Interview with the Director of Nursing (DNS) on 9/25/25 at 1:56 PM identified that bi-monthly narcotic audit logs were not located prior to her start date in August 2025. Interview with the DNS on 9/25/25 at 2:45 PM identified the bi-monthly audit logs prior to September 2025 were completed by the previous DNS and could not be located. Further identified the bi-monthly audit logs should be kept and stored for 3 years and the DNS was responsible. Review of the Controlled Medications Policy dated 2025 directed, in part, when completed, audit and accountability records are submitted to the Director of Nursing and kept on file for three years at the facility.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on tour of the Dietary Department, staff interview and review of facility policy, the facility failed to ensure proper hair covers were worn while in the kitchen, they also failed to ensure items in the kitchen were consistently dated and labeled. The findings include: The tour of the Dietary Department on 9/22/25 at 9:24 AM with the Director of Dietary identified the following:a. The Dietary Manager was observed with a full beard, standing over the food preparation area that contained a tray of uncovered ham, and carrots with no beard covering on to cover his beard. Interview with the Dietary Manager on 9/22/25 at 9:24 AM identified that a hair covering should be worn by all persons in the kitchen but did not provide a reason his beard was not covered while in the kitchen and near food. Facilities Dress Code Policy indicated in part that Hairnets or Hats must be work at all times, hair restraints must completely cover the hair line at all times, beard guards needed to be worn as appropriate. b. Observation on 9/22/25 at 9:32 AM with the Dietary Manager identified that the meat freezer had 1 open bag of a meat like substance described by Dietary Manager to be chicken cutlets with no label to identify the item, and no date to indicate when it was first opened. There were also 3 additional unopened bags of (chicken cutlets according to Dietary Manager) with no labels to indicate the size/ounces of the bag, expiration date or what the item was. Additionally, 1 unopened bag of breaded meat described by Dietary Manager to be fish patties, which did not have labels to indicate what the item was or an expiration date. Prior to observation of the refrigerators and freezers, the Dietary Manager reported that all items were expected to be dated and labeled of what the item was (if removed from original package) and when it was opened.Subsequent to surveyor inquiry, the Dietary Manager began dating and labeling the bags he described as chicken cutlets.c. Observation on 9/22/25 at 9:38 AM of the Pastry fridge noted one 10 inch weight 10.13 lb Strawberry Cream Pie and 1 pound cake(size unknown) with no use by date/expiration date.d. Observation of the Dry storage room at 9:52 AM on 9/22/25 noted 3 cans (6 pound 3 ounces) of shredded sauerkraut with no expiration date and observation at 9:55 AM of an open pack of chocolate cake with no open date or use by date. Interview with the Dietary Manager on 9/22/25 at 9:38 noted he was unable to provide why the cans did not have an expiration date. Subsequent to inquiry Dietary manager contacted the food service distributor of the cans to receive the self-life of the aforementioned items. Review of Facilities perishable dating Policy indicates in part, all items stored in the refrigerator will be dated the date opened.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 4 residents reviewed for mistreatment, the facility failed to ensure that the residents were free from a resident-to-resident altercation. The findings include: 1. Resident #20 ?s diagnoses included dementia with other behavioral disturbance, anxiety disorder, adjustment disorder and depressed mood. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was cognitively impaired, having behavioral history of rejecting evaluation or care. The MDS further identified Resident #20 required assistance for sit-to-stand transfers and supervision or touching assistance for bed mobility.The Resident Care Plan dated 6/27/24 identified Resident #20 could be physically and/or verbally aggressive toward staff members or other residents. Interventions included to approach Resident #20 slowly and from the front, attempt to involve Resident #20 in 1 to 1 recreational activity, be sure to have his/her attention before speaking or touching him/her, offer a consult with psychiatric services and to use consistent routines (timing and sequencing) for Activities of Daily Living. A physician's order dated 7/26/24 directed to give 25 milligrams (mg) Trazodone (a medication to treat depression) by mouth (PO) every day as needed (PRN) for anxiety for 14 days. 2. Resident #46 ?s diagnoses included chronic diastolic (congestive) heart failure, type 2 diabetes mellitus and paranoid schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was cognitively intact. The MDS also indicated Resident #46 exhibited behavior of delusional symptoms and was independent with transfers and lower body dressing. The Resident Care Plan dated 7/1/24 identified Resident #46 had paranoid schizophrenia disorder and was at risk for changes in mood state and behaviors. Interventions included to watch for and report new onset or increase in symptoms, delusions, hallucinations, impaired communication and speech, bizarre or unusual behavior, symptoms of depression, periods of manic mood and follow up with the psychiatrist as scheduled or as needed. A nursing note dated 8/5/24 at 4:01 PM identified, the nurse was called by the Nurse Aide (NA) at 2.30 PM. Summoned to the hallway where Resident #20 had fallen. Resident #20 was observed in a semi-lateral position with mild bleeding from an open area to the scalp. He/she denied pain and discomfort. Upon assessment, Resident #20's neurological vital signs were at baseline, pupils were equal and reactive to light, hand grasps equal and weak. Resident #20 was not able to give correct information because of confusion. According to another resident (Resident #46), he/she slapped Resident #20, kicked him/her and Resident #20 fell on the floor. The APRN was informed, a new order was obtained to send Resident #20 to the emergency room for evaluation, activated 911 and Resident #20 was transferred to the hospital for further evaluation. Nursing notes dated 8/5/24 at 10:40 PM identified Resident #20 returned to the facility from the hospital having had a neurological and vital sign evaluation; as well as, an assessment indicating resident was not a current danger to themself or others and had no injuries. No new orders were received upon Resident's #20 return to the facility. A facility obtained statement dated and signed on 8/5/24 from Nurse Aide (NA) #1 (7:00 AM to 3:00 PM shift) indicated I sat down to chart at the NA station, I heard someone yelling 'help' I got up and saw Resident #46 hurrying back into his/her wheelchair and Resident #20 was on the floor. NA #1 asked Resident #46 what happened and he/she said Resident#20 kicked him/her, so he/she retaliated. A facility obtained statement signed and dated 8/6/24 by Registered Nurse (RN) #1 indicated a NA called for help and RN #1 saw Resident #20 on the floor, in a semi-lateral position, with mild bleeding coming from the wound (open area). Resident #20 was not giving accurate statements because of his/her baseline confusion. According to Resident #46, Resident #20 kicked him/her and so Resident #46 pushed Resident #20 and both fell on the floor.A facility Accident and Incident report dated 8/5/24 indicated an unwitnessed incident in which Resident #46 stated Resident #20 was kicking him/her. Resident #46 reported standing up and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pushing Resident #20 off of him/her. Both residents were found on the floor. Resident #46 reported that he/she crawled back to his/her chair.Injuries noted on Resident #46 at time of incident was an abrasion to the left kneeInterview with Resident #46 on 9/22/25 at12:20 PM did not provide any additional details related to the incident and only stated it's good now. Interview with NA #1 on 9/24/25 at 11:07 AM indicated that she called the nurse over and waited with Resident #20 as the resident remained on the floor to be evaluated. She reported the residents were not separated at the time after the incident. She reported she didn't recall anything being in the hallway that resident could have hit while falling.Attempts to contact the RN on shift that day were made but unsuccessful.Interview with the Administrator on 9/26/25 at 10:33 AM indicated she was familiar with the incident, though she was off that day. She reported that Resident #20 was sent to the emergency room as a result of the resident-to-resident altercation. She reported due to the pushing, and this altercation would be considered a form of abuse. She reports their policy indicated that residents are immediately separated, seen by psychiatric services and offer room change if applicable. Facilities Abuse policy indicated in part that all residents are treated with kindness, compassion and dignity. abuse or mistreatment of any kind towards a resident is strictly prohibited.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interview for the only resident reviewed for edema (Resident #61), the facility failed to ensure staff submitted Minimum Data Set (MDS) assessments timely. The findings include: Resident #61's diagnosis included heart failure, depression and Hypertension.A quarterly MDS assessment dated [DATE] indicated Resident #61 had moderate cognitive impairment.On 8/28/25 Resident #61 was admitted to the hospital.On 9/4/25 Resident #61 was readmitted to the facility.The facility scheduled and was in the process of completing an annual MDS assessment combined with a discharge return anticipated assessment when Resident #61 was admitted to the hospital on [DATE]. (The facility can complete assessments earlier but no later than 90 days after the date of the last assessment).On 9/24/25 at 9:40 AM an interview and MDS review with Registered Nurse (RN) #2 who completed the MDS', indicated the MDS assessments for Resident #61 had not been completed as of this date and were not completed timely: Entry MDS dated [DATE] to be completed by 9/11/25(13 days late),The annual discharge return anticipated (DRA) assessment along with the care plan decisions should have been completed by 9/20/25 (4 days late), the entry assessment dated [DATE] was to have been completed by 9/21/25 (3 days late), RN #2 indicated he/she was behind in completing the assessments, was the only nurse completing MDS assessments at the facility and at times assists on the units to complete other duties when needed. RN #2 indicated the corporate managers for the facility could be made aware that assistance was needed and planned to do so, subsequent to surveyor inquiry. RN #2 further indicated he/she was told the MDS assessments for September were due on September 15th but would refer to the RAI manual for CMS guidance.The facility policy labeled MDS dated as reviewed 8/19/25 indicated in part the MDS will be completed according to the procedures and directives outlined in the MDS RAI Manual. The Resident Care Coordinator (RCC or MDS Nurse) shall determine the schedule of the MDS assessments to be completed and notify disciplines responsible for completing the MDS. The MDS assessments will be submitted to the QIES data base by an automated MDS submission process through the facility electronic documentation system within 14 days of the completion date of the MDS.MDS Validation Reports were requested but not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documents, interviews and facility policy for 1 of 4 residents (Resident #24) reviewed for nutrition, the facility failed to ensure weights were documented monthly according to physician orders. The findings include:Resident #24 ?s diagnoses included having a Stage 4 pressure ulcer to the sacrum, hypotension and neuromuscular dysfunction of the bladder.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 24 was cognitively intact and was dependent with eating, oral hygiene and chair to bed transfer.The Resident Care Plan dated 7/3/25 identified Resident #24 did not have any behaviors of refusing care.A physician's order dated 10/1/24 directed to obtain Resident #24's weight on the first shower day of the month; every day shift starting on the 1st and ending on the 7th every month.Review of the monthly weights failed to identify monthly weights had been documented as physician ordered from May 2025 through September 2025.The Treatment Administration Records (TAR) for March 2025 indicated a weight was obtained on 3/2/25, however, the weight was not documented in the weights/vitals tab, nor does the TAR identify what the weight was that was obtained that day.The TAR for June 2025 indicated weights were taken on 6/1/25, 6/5/25 and 6/7/25 but failed to identify what the weights were from those dates.The TAR for July 2025 indicated on 7/6/25, a weight was obtained but failed to identify what the weight was.The August 2025 TAR indicated on 8/6/25 a weight was obtained; however, the weight was not documented.The September 2025 TAR indicated on 9/5/25 a weight was obtained; however, a weight was not documented.Review of Resident #24's paper chart does not reveal any weights documented for the missing months.Interview with the DNS on 9/24/25 at 10:13 AM indicated all weights should be documented in the weights/ vital tab, during the shift it was taken. She indicated that all refusals should be documented in notes section each time and if the resident had refusal behaviors then it should be care planned for. The DNS was unsure of the reason weights were not consistently taken or documented. She reported acknowledging that weights were an issue for the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record and facility documentation, interviews and facility policy for 1 of 3 residents (Resident #61) reviewed for falls, the facility failed to ensure supervision was provided in the bathroom, resulting in Resident #61 falling without injury. Additionally, the facility failed to ensure staff remained with food items while re-heating in a microwave to prevent the occurrence of smoke that required the activation of a code red and the fire alarm resulting in the fire department being dispatched. The findings include: 1. Resident #61's diagnosis included congestive heart failure, constipation, history of urinary tract infection and history of falls. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 had intact cognition and required partial/moderate assistance for toileting, upper/lower body dressing and personal hygiene. Additionally, the MDS identified Resident #61 had a fall in the last month prior to admission and had 1 fall since the prior MDS assessment.The Resident Care Plan (RCP) dated 4/7/25 indicated Resident #61 was at risk for falls due to multiple risk factors including impaired balance, unsteady gait and pain. The RCP indicated Resident #61 had a fall on 3/21/25 with an intervention to place a walker within reach. The RCP indicated Resident #61 had another fall on 4/10/25 with an intervention added to remind Resident #61 to wear proper footwear/nonskid socks when out of bed. Other interventions already in place were to encourage the resident to transfer and change positions slowly, encourage Resident #61 to use handrails or assistive devices properly, physical and occupational therapy to help increase strength and endurance, offer to organize personal items so they are within reach, to wear slipper socks while in bed and provide transfers per the physician's orders. The care plan indicated Resident #61 was at risk for constipation with interventions in-place including to assist resident #61 to meet toileting needs and provide incontinent care as needed. A physician's order dated 4/15/25 directed to transfer Resident #61 with the assistance of 2 persons and no device while another physician order of the same date directed to use a rolling walker with transfer. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #61 had a severe cognitive impairment and was dependent on staff for toileting, toileting hygiene, and transferring from bed to chair. A facility Reportable Event (RE) form dated 5/29/25 at 10:15 PM indicated Resident #61 after being walked to the bathroom by a Nurse Aide (NA) using the resident's walker, was instructed by the NA (Resident #61 was severely cognitively impaired) to use the call light when done in the bathroom and was left in the bathroom by the NA. Resident #61 was witnessed walking out of the bathroom by him/herself, not having utilized the call light for assistance and fell while trying to use the wall mounted hand sanitizer. The RE indicated Resident #61 was not injured and was able to get up and get back to bed. A facility RE dated 6/14/25 at 9:14 AM (16 days after the last fall) indicated Resident #61 had a witnessed fall after NA #4 walked Resident #61 to the bathroom with a walker, NA #4 stood in the doorway of the bathroom and Resident #61 attempted to go toward the toilet, tripped over his/her own feet and fell sitting on the floor. The RE indicated Resident #61 required the assistance of 1 person with a walker but did not reflect the current physician's transfer order for 2-person assistance for transfer and to use a rolling walker for transfers. An intervention entry on the fall RCP dated 6/16/25 (2 days after the fall) indicated to utilize a gait belt when ambulating Resident #61. An interview, facility document review, clinical record review and facility policy review on 9/25/25 at 12:10 PM with the Administrator, the DNS and RN #2 present, reviewed the falls sustained by Resident #61 on 5/29/2025 and 6/14/25, During review of the fall of 6/14/25 the fall investigation found the NA #4 was standing in the doorway while Resident #61 was in the bathroom attempting to turn towards the toilet and the physician orders indicated 2 person transfer assistance with the use of a walker, the DNS indicated the NA should have had hands on the resident and another person assisting the transfer and the orders should have been on the care card to follow. The DNS and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator clarified the NA Care cards were written in pencil without dates and were erased when changed, no copies of each care card were kept when changes were made further indicating when an order was written it was transcribed to the care card. At the end of review of each fall with the Administrator and DNS, it was noted the falls were related to Resident #61 going to the bathroom unassisted, not utilizing the call bell and waiting for assistance. The DNS who had not worked at the facility during the time Resident #61 had the recurrent falls noted Resident #61 had some cognitive fluctuations. While discussing Resident #61's cognitive status over the time period of the falls the DNS indicated to remind and expect Resident #61 to use the call bell would not have been an appropriate intervention as Resident #61 would not have been able to remember to use the call bell and the staff would have had to intervene to toilet the resident. On 9/25/25 at 9:56 AM an interview with NA #3 indicated having worked as a regular aide on the unit and was assigned to Resident #61 when the falls occurred, indicated the assignment indicated Resident #61 required 1 person assistance (a discrepancy with the physician orders dated 4/15/25 directing to transfer Resident #61 with the assistance of 2 persons), the call light within reach but the resident would not use the call bell, would get up unassisted and sometimes the roommate would ring the call bell to alert staff Resident #61 was on the floor. NA #3 indicated when Resident #61 was awake he/she was less confused but if just awoke he/she would be confused. Sometimes NA #3 indicated he would ask Resident #61 if he/she wanted to go to the bathroom or he would change the incontinent brief if it was soiled but the assignment did not say to wake Resident #61 with every 2-hour round on the third shift. When NA #3 was read the statement written after a fall on 6/23/25 indicating no care was provided prior to the fall and resident was asleep, NA #3 added he checked Resident #61's incontinent brief each round and changed it if incontinent. NA #3 indicated at times Resident #61 would use the call bell other times not as his/her mentation varied. NA #3 further indicated once the resident got up on his/her own, Resident #61 never used the walker. On 9/26/25 at 9:45 AM an attempt to reach RN #9 (the RN on duty during the fall that occurred on 6/14/25 at 9:24 AM) was unsuccessful. On 9/25/25 at 12:46 PM, an interview with NA #4 (who was the NA assigned to and who walked Resident #61 to the bathroom on 6/14/25 and stood in the door way while Resident #61 attempted to turn onto the toilet and then fell), indicated she assisted the resident with the walker, had to stand in front of the walker (in the door way) as there was little room in the bathroom, it seemed Resident #61's leg twisted, having no hold on the resident, the resident fell. NA #4 indicated she refers to the care card for information needed to transfer and care for a resident further indicating the care card indicated Resident #61 required the assistance of 1 person (and not 2 persons per physician orders dated 4/15/25). On 9/29/25 at 8:27AM an interview with RN #9 who worked as the charge nurse on Resident #61's unit on 6/14/25 (when Resident #61 had a witnessed fall in the bathroom with NA #4) indicated only working Per Diem (as needed) on the weekends and could vaguely recall the incident, was unaware how the nurse aides obtained the information they needed to care for each resident and could not recall Resident #61's transfer order status on that day but did indicate the NAs carried a sheet of paper with them but was not sure what was on the paper.The facility policy labeled Falls, dated as reviewed on 8/19/25, indicated in part the purpose of the policy is to identify residents at risk for falls,, minimize fall related injuries and to develop and revise interdisciplinary care plans to address falls and injury risk. The policy indicated that all falls would be documented, investigated and used to inform care planning. An Accident and Incident Report would be completed for each fall obtaining staff statements for every fall event, the resident's care plan would be updated with individualized interventions and injury prevention strategies after every fall including updating the resident's care card with the fall risk and corresponding precautions. The policy also indicated all fall would be reviewed regularly in the facility at risk meetings to identify trends or recurring risk factors. 2. On 9/26/25 at 8:20 AM, upon entry into the facility a fire truck, without sirens activated pulled into the facility parking lot and up to the front door. The surveyor was met at the front entrance by the DNS who indicated there was a smoke issue with a microwave, staff pulled the fire alarm and were (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	awaiting the fire men to initiate and all clear before anyone can enter or leave the building. On 9/26/25 at 8:25 AM the announcement of all clear was made in the facility and the DNS opened the front door to the facility. On 9/26/25 at 8:28 AM, an interview and observation with the Administrator of the microwave in the nourishment area on the [NAME] Wing. The microwave was found to be unplugged, warm to touch and a brown discoloration was noted on the interior. The Administrator indicated the microwave would be removed momentarily once cooled down and had indicated some pizza was being reheated by staff, the incident was actively investigated and once the incident report was completed a copy would be provided to the team leader of the survey. On 9/26/25 at 8:30 AM an interview with Administrator #2 indicated it was unlikely that prior in service training of nursing staff was completed regarding proper use of the nourishment room microwaves and further indicated there was no policy or procedure for the use of this microwave (heating, re-heating, staying with food during the heating process), but the facility would develop one. On 9/26/25 at 8:42 AM, the State Agency was notified by the facility Administrator of an event of smoke at the facility. Staff had observed smoke and a burning smell on the [NAME] Wing resulting in the fire alarm being pulled and emergency services activated. A Code RED (a term for the need of all staff to respond to a fire situation) emergency was activated and the facility initiated the Code RED protocol. On 9/26/25 at 11:40 AM an interview and facility document review with the Administrator identified Nurse Aide (NA) #8 placed a piece of pizza in the [NAME] Wing nourishment area microwave, left it unattended while heating, resulting in smoke noted and the need for the fire alarm to be activated. On 9/26/25 at 1:10 PM an attempt was made to interview NA #8 but was unsuccessful.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews and review of the facility policy for the only resident reviewed for dialysis (Resident #8), the facility failed to ensure that a resident on dialysis and with a fluid restriction had fluid intake consistently monitored and documented as per facility policy. The findings include: Resident #8's diagnoses included end-stage renal disease and dependence on renal dialysis.A physician order dated 6/13/25 directed a 1500 milliliter (ml) fluid restriction.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was severely cognitively impaired, required partial/moderate assistance with oral hygiene and was dependent for toilet and personal hygiene. The MDS further identified Resident #8 was receiving dialysis since admission.A hydration risk assessment dated [DATE] identified that Resident #8 was on fluid restrictions and that intake and output (I&O's) had been initiated for at least 72 hours. A physician order dated 8/1/25 directed a 1500 ml fluid restriction.Hospital discharge records dated 8/19/25 indicated that Resident #8 was admitted to the hospital on [DATE] for acute hypoxic respiratory failure due to volume overload and underwent urgent dialysis. Resident #8 was then discharged back to the facility on 8/19/25. A physician order dated 8/19/25 directed a 1,500 ml fluid restriction.A Resident Care Plan dated 8/21/25 identified that Resident #8 had a potential for nutritional decline related to a recent hospitalization from 8/12/25 to 8/19/25. Interventions included recording intake and output (I&O) as ordered. The care plan did not identify any fluid restrictions despite physician orders directing a 1500 ml fluid restriction. A Nutritional assessment dated [DATE] indicated that Resident #8 was on a renal diet and on a 1500 ml per day fluid restriction. The nursing care card failed to identify a fluid restriction or Intake/Output monitoring. The Intake/Output Report located in the paper chart from 7/14/25 to 9/23/25 identified that the Intake/Output Report was not consistently filled in for every shift, and all days were missing a total 24 hour calculated intake. Additionally, for 7/14/25, 7/15/25, 8/3/25, 8/6/25, 8/21/25, 8/22/25, and 8/29/25, there was no recorded intake on any of the three shifts, and there was no calculated 24-hour total documented.Nursing notes from 7/13/25 to 8/30/25 and a review of physician orders identified that Resident #8 was in the facility with an active fluid restriction order during those dates. On 9/24/25 at 2:20 PM, an interview and I&O record review with Licensed Practical Nurse (LPN) #1 identified that no I&Os were recorded for 7/14/25, 7/15/25, 8/3/25, 8/6/25, 8/21/25, 8/22/25, and 8/29/25, that the Intake/Output Report was not consistently filled in for every shift and all days were missing a 24-hour total calculated intake. LPN #1 indicated that the regular staff were very good at documenting I&O's, but that some agencies might not know how to document them. LPN #1 indicated that there was no list on the unit of residents who were on I&O's or on fluid restrictions, but that residents on dialysis would automatically have I&O's documented. LPN #1 further indicated that the only place for documenting Intake/Output was on the paper Intake/Output Report and not in the electronic health record. Subsequent to the surveyor's inquiry, a physician order for Intake/Output was obtained on 9/24/25. On 9/25/25, an interview with the DNS identified that the policy for hemodialysis indicated to only record I&O's for residents who were non-compliant. Further, the DNS indicated that to track a fluid restriction of 1500 mL, staff would need to be monitoring intake and that when filling the Intake/Output Report, staff should be documenting every shift and totaling every day. A review of the facility policy for Intake and Output Monitoring identified that I&O monitoring was not automatically initiated for all residents upon admission, and I&O would be initiated only when clinically indicated based on the results of hydration risk screening. Additionally, the I&O policy indicated that staff were to total 24-hour I&O and notify the provider of abnormal findings. However, a review of the facility policy for Hemodialysis identified that staff were to maintain fluid restrictions as ordered. The Hemodialysis policy also indicated staff were to monitor I&O and notify the physician and dialysis if the resident is non-compliant with fluid restrictions.

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	11/25/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documents, interviews and facility policy for 1 of 5 residents (Resident #32) reviewed for unnecessary medication, the facility failed to ensure facility staff/pharmacy completed monthly medication reviews for 3 months. The findings include: Resident #32's diagnosis included Type 2 diabetes, depression, anxiety anemia hypothyroidism, hypertension and bipolar disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 received insulin injections, antidepressants, antianxiety medication, anticonvulsant medication, and hypoglycemic medications. The Resident Care Plan (RCP) dated 11/13/24 indicated Resident #32 was at risk for adverse effects of hypothyroidism with interventions that included to provide medication and obtain lab work as ordered while observing for adverse signs and symptoms. The RCP also indicated Resident #32 was at risk for complications related to diabetes and the risk for low or elevated blood sugar levels. Interventions included to administer medications, check blood sugars levels and lab work as ordered and to watch for adverse effects of the medications as well as other medical complications. The RCP further indicated Resident #32 was at risk for potential adverse effects from the use of psychotropic medication with interventions that included to provide medications as ordered, observe for medication side effects, monitor vital signs and obtain lab work as ordered. A quarterly Minimum Data Set (MDS) assessment dated [DATE], 5/3/25 and 8/1/25 indicated Resident #32 received insulin injections, antidepressant, antianxiety, and hypoglycemic medications and the care plan at this time remained unchanged.Review of pharmacy medication monthly reviews failed to identify Resident #32's monthly medication regimen was reviewed by the pharmacist for November 2024, February 2025 and June 2025. On 9/25/25 at 8:27AM, an interview with the DNS indicated the facility had transitioned to a new pharmacy months ago and when the DNS started working at the facility mid-August 2025 she did not find monthly pharmacy regimen reviews and recommendation forms were blank. The DNS further identified after meeting with the current pharmacy, a plan was made to provide the review/recommendations to the DNS and a new APRN for the facility had been in place for a few weeks who would address the recommendations timely. On 9/25/25 at 3:10 PM attempts to reach the previous pharmacy consultant, (Pharmacy Consultant #1), were unsuccessful. The facility policy labeled Drug Regimen Review- With Consultant agreement only dated reviewed 08/19/2025 indicated in part A Drug Regimen Review reviews, analyzes prescribed medications therapy and use including nursing documentation of medication ordering and administration of which the consulting pharmacist reviews every residents medication Regimen at least monthly, findings and recommendations are forwarded to the Administrator, Director of Nursing Services, the primary care physician, and the medical director where appropriate. The consultant pharmacist documents the date each review is completed on the appropriate form and notes the findings further indicating that every resident must have a drug regimen review along with a medical record review monthly. The policy further indicated the facility is to maintain copies of the drug regimen review reports and physician signed pharmacy recommendations for at least one year.

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F 0584 Level of Harm - Potential for minimal harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews for the only resident (Resident #32) reviewed for environment, the facility failed to ensure bureau drawer knobs were in place to ensure resident access to the use of a facility supplied bureau. The findings include: Resident #32's diagnosis included anxiety and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 was cognitively intact and required set up or supervision for dressing, walking and wheeling the wheelchair. An observation and interview with Resident #32 on 9/22/25 at 11:11 AM noted two lower bureau drawers with the knobs missing and the screws exposed (sticking out) where the knobs once were, rendered the drawers unusable to the resident. An observation, interview and review of facility documentation with the Director of Maintenance on 9/25/25 at 1:45 PM indicated the unit Resident #32 resided on had older bureaus and nightstands and frequently the drawer knobs come off and had to be glued back on. The Director of Maintenance indicated when there was a repair needed on the unit, staff members were to write it in the maintenance book on the unit, then maintenance staff look in the book, repair the issue and sign it off. Review of the entries in the maintenance book found no entries made for Resident #32's missing bureau knobs. Observation of Resident #32's roommate's bureau also noted knobs of the lower drawers missing, with some of the screws sticking outward. The Maintenance Director indicated he/she would replace the knobs for both residents immediately. The Maintenance Director further indicated every resident room was looked at during quarterly Environmental rounds and that a logbook was created which identified all of the bureau knobs already replaced, but was unable to produce the logbook. An interview and facility document review on 9/25/25 at 2:00 PM with the Infection Preventionist (LPN #4), indicated Environmental rounds were conducted quarterly with the supervisor of the area being looked into as well as the maintenance director and documented.Review of the most recent facility Environmental rounds dated 6/2/25 listed night stands were looked at but did not identify the bureaus were observed and indicated no issues for the nursing areas. LPN #4 indicated not remembering seeing any knobs missing off the bureaus during the 6/2/25 rounds. On 9/25/25 at 2:10 PM the Administrator along with LPN #4 present was made aware of the bureau knobs missing and indicated he/she would look into the issue. Interviews with Nurse Aide (NA) #9, #10 and #11 on 9/26/25 at 9:23 AM who were working the [NAME] Wing indicated not having noticed knobs missing off bureaus or nightstands or residents asking for them to be repaired. NA #9 indicated if he/she noticed a repair was needed or a resident made a request he/she would inform the maintenance worker in person when on the unit. An interview on 9/26/25 at 9:23 AM with LPN #1 who was Resident #32's charge nurse indicated not having noticed knobs missing and was surprised to see them missing. LPN #1 indicated in the event a resident informed him/her of something being broken/needing repair he/she would verbally report the incident to maintenance and could write it in the maintenance logbook as well. Subsequent to surveyor inquiry, an observation on 9/26/25 at 1:15 PM noted the drawer knobs were provided and put in place on the lower drawers of the bureaus located in the shared room of Resident #32.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and interviews for 1 of 1 sampled resident (Resident #15) reviewed for hospice services, the facility failed to accurately code the quarterly Minimum Data Set (MDS) assessment to reflect Resident #15 receiving hospice services. The findings include: Resident #15 was admitted to the facility in 2020 with diagnoses that included malignant neoplasm (cancerous growth) of the breast, transient cerebral ischemic attack (temporary blockage of blood flow to the brain that causes stroke-like symptoms), aphasia (affects a person's ability to communicate), atrial fibrillation and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, required the assistance of 2 or more with toileting hygiene, showers, upper/lower body dressing, personal hygiene, and required maximal assistance with transfers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, required the assistance of 2 or more with toileting hygiene, showers, upper/lower body dressing, personal hygiene, and transfers. The Resident Care Plan (RCP) dated 6/25/25 identified Resident #15 was receiving hospice level of care from a contracted hospice agency and death was expected due to illness. Interventions included to control pain, symptoms, maintain dignity and arrange clergy visits as requested. A physician's order dated 8/14/25 directed hospice services effective from 8/19/24. On 9/26/25 at 11:45 AM, interview and review of the 2/26/25 and 6/20/25 MDS' with Registered Nurse (RN) #5 failed to identify the MDS' were coded to reflect Resident #15 entering into hospice services from 8/19/24. Interview with RN #6 on 9/26/25 at 12:16 PM identified Resident #15 was already on hospice services when the MDS dated [DATE] was coded incorrectly. Review of the MDS Policy directed, in part, the MDS 3.0 will be completed according to the procedures and directives outlined in the MDS RAI Manual. Section O of the MDS relates to special treatments, procedures and programs and code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.