

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for Leave of Absence (LOA), the facility failed to ensure a resident who is dependent on staff for transfers, Activities of Daily Living (ADLs) and severely impaired cognition was accompanied to a medical appointment out in the community, resulting in the resident being dropped off at the wrong location, then dropped off by an unknown person to the emergency department. The findings include:</p> <p>Resident #1 had diagnoses that included mild cognitive impairment, seizures, diabetes mellitus, peripheral vascular disease, and bipolar disorder.</p> <p>The clinical record failed to identify an LOA order.</p> <p>The quarterly MDS dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of five (5) indicative of severely impaired cognition, has impaired vision, dependent with ADLs and transfers.</p> <p>The care plan dated 10/8/24 identified Resident #1 needs assistance with ADLs due to cognitive deficit with interventions that direct to assure Resident #1 is accompanied to medical appointments as deemed necessary per facility policy.</p> <p>The nurse's note dated 11/12/24 at 2:32 P.M. written by LPN #3 identified Resident #1's daughter called, and she scheduled a vascular appointment for Resident #1, the family member will meet Resident #1 at the appointment.</p> <p>A nurse's note dated 11/20/24 (Late entry) at 9:42 A.M. written by the Assistant Director of Nursing (ADNS) identified that Resident #1 was scheduled for a vascular appointment. The appointment was changed to another location and the facility was not made aware. The ADNS indicated she called the transportation company who agreed to go back to transport Resident #1 to the other address. The ADNS indicated she spoke with Resident #1's family member who was on her way to meet Resident #1 at the original location and Resident #1's daughter acknowledged she was not made that the location of Resident #1's appointment had been changed. The ADNS identified she provided Resident #1's family member with the address of the new location of the appointment and she would to go meet Resident #1 at the appointment.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's note dated 11/20/24 (Late entry) at 3:37 P.M. written by the ADNS identified she was alerted by RN #2 (supervisor) that Resident #1's family member called the facility looking to see if Resident #1 made it back because Resident #1 never came to the appointment. The ADNS identified another family member called the facility and stated that Resident #1 was dropped off at the wrong location and Resident #1 was transported to the emergency room by an unknown person. The ADNS identified Resident #1 returned to the facility via car Resident #1 was transported by a family member.</p> <p>Review of the emergency department observation note dated 11/20/24 at 2:00 P.M. identified Resident #1 was dropped off at the door in a wheelchair with no family or staff. Resident #1 is unable to provide history due to cognitive impairment. Resident #1 does have paperwork that has h/her medical history, medication, and name of the facility h/she is from. Collateral information obtained from the facility Resident #1 was supposed to go to a vascular appointment today with an aide, instead, Resident #1 reportedly was dropped at the wrong address and then from there dropped off at the emergency department. Resident #1 discharged from the emergency department back to the facility accompanied by a family member.</p> <p>Interview with the ADNS on 12/13/24 at 11:40 A.M. identified on 11/20/24 Resident #1 was picked up at the facility by the transportation company, and sent out unaccompanied for h/her appointment, and dropped off at the appointment. The ADNS indicated she received a call from the MD office reporting that Resident #1 had not arrived for h/her appointment. The ADNS identified that the MD office informed her the location of Resident #1's appointment had changed. The ADNS indicated prior to 11/20/24 that the MD office had not communicated that the location of Resident #1's appointment had been changed. The ADNS indicated she contacted the transportation company who agreed they would have the driver return to the original MD address and transport Resident #1 to the appointment at the new location of the MD appointment. The ADNS indicated she contacted Resident #1's family would meet Resident #1 at the new location.</p> <p>Interview with RN #2 on 12/13/24 at 3:25 P.M. identified on 11/20/24 she tried to contact Resident #1's family prior to the resident leaving, but was unable to reach her. RN #2 identified a nurse aide was not assigned to accompany Resident #1 to h/her appointment. RN #2 indicated she spoke with Resident #1 and Resident #1 indicated h/her daughter would be meeting Resident #1 at the appointment. RN #2 identified when a resident is going out to a medical appointment if it is noted that the resident's family will accompany the resident the family needs to be present in the facility prior to the resident leaving the facility. RN #2 indicated it was a miscommunication and Resident #1 should not have been sent out to h/her appointment unaccompanied.</p> <p>Interview with the DNS on 12/13/24 at 1:00 P.M. identified when a resident is going out to a medical appointment with family the family must be physically present in the facility prior to the resident leaving the building or a nurse aide must accompany the resident. The DNS identified on 11/20/24 when Resident #1's daughter was not present in the facility to accompany The DNS identified on 11/20/24 Resident #1 should not have left the facility with the transportation company alone to go to h/her medical appointment. The DNS identified on 11/20/24 RN #2 was provided with employee coaching because RN #2 sent Resident #1 who requires assistance, is cognitively impaired, and wheelchair bound out to h/her appointment unaccompanied. The DNS identified supervisors are responsible for assuring the resident's family is present at the time of pick up or a nurse aide is assigned to accompany the resident to the appointment. The DNS stated that it is unclear how the resident ended up at the emergency department.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the MD #1 (Medical Director) on 12/13/24 at 2:25 P.M. identified his expectation is when a resident is going out for an appointment a family member, or a staff member must accompany the resident. MD #1 identified on 11/20/24 Resident #1 should not have been sent out alone to h/her appointment and Resident #1 should have been accompanied by a staff member.</p> <p>Review of the undated facility MD appointment/Offsite/Transportation policy identified the purpose of the policy is to ensure the safety of residents going to offsite M.D. appointments and assist with transportation to and from any appointments. In instances where the resident requires supervision on medical appointments, the resident's family/responsible party may be contacted to attend the appointment. If the family is unable to attend and the facility is unable to provide a staff member to accompany the resident, the appointment may have to be rescheduled.</p>		