STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075389	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Laurel Woods	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)
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 clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident abuse, the facility failed to ensure Resident #1 was not verbally abused by staff. The findings include: Resident #1's diagnoses included schizoaffective disorder, cognitive communication deficit, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had some memory recall deficits, had not exhibited behavioral symptoms, and was dependent on staff for toileting. The Resident Care Plan dated 2/20/25 identified Resident #1 required assistance with incontinent care. Interventions directed to assist the resident with incontinent care timely and assist the resident in and out of bed during the day. The Facility Reported Incident form dated 3/2/25 identified at 3:40 PM Resident #1 reported having an interaction with an 11PM-7AM nurse aide, Nurse Aide (NA) #1, on 3/2/25 that upset him/her. Resident #1 requested that NA #1 no longer provides care for him/her. The nurse's note dated 3/3/25 at 2:02 PM identified the Social Worker and the Assistant Director of Nursing provided support to Resident #1 following a concern of staff to resident interaction. The note identified Resident #1 expressed concern regarding a nurse aide being argumentative on the prior overnight shift. Resident #1 reported staff had been supportive, he/she feels comfortable and safe at the time. The summary report dated 3/4/25 indicated on the 11PM- 7AM shift, 3/1/25 into 3/2/25, Resident #1 reported he/she had an interaction with NA #1 that he/she found upsetting and Resident #1 expressed concern about the way the situation was handled by NA #1. The report indicated the interaction did not reflect a level of professionalism and resident care that the facility expected from the team. NA #1 was suspended pending the investigation and then terminated. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON) on 3/26/25 at 11:25 AM identified on 3/2/25 the 3PM-11PM Nursing Supervisor called her at approximately 3:00 PM to report that the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, told her she was made aware by a 3PM-11PM nurse aide, NA #2, that Resident #1 had an audio recording of an interaction that occurred between Resident #1 and NA #1 on 3/2/25 at approximately 2:00 AM. The ADON indicated she met with Resident #1 and listened to the recording which was very disturbing. The ADON explained when NA #1 entered Resident #1's room to provide care, Resident #1 inquired why it took so long for NA #1 to come back into his/her room to change him/her at which time the two (2) began to argue and NA #1 became extremely argumentative, and her voice escalated. The ADON identified the recording revealed Resident #1 had asked NA #1 to leave the room several times and NA #1 was heard refusing to leave the room, Resident #1 requested to see a supervisor several times and at one (1) point NA #1 said no, and Resident #1 was heard telling NA #1 to stop touching him/her several times. The ADON identified NA #1 should have left the room when Resident #1 requested she leave the room. The ADON explained Resident #1's roommate told her NA #1 was very rude, and he/she was scared the nurse aide was going to hit Resident #1, so she turned his/her light on. Interview with Resident #1 on 3/26/25 at 12:45 PM identified although he/she could not recall the exact date of the altercation with NA #1, he/she was able to recall the details as written in his/her original statement. Resident #1 stated he/she recalled pressing the call bell at approximately 1:00 AM requesting assistance to be changed and NA #1 came into his/her room and said she would be back as soon as she could, however an hour passed, so Resident #1 explained he/she called again. Resident #1 indicated when NA #1 entered the room, he/she began to question her about the delay and NA #1 became belligerent and argumentative. Resident #1 stated he/she played the audio recording and the contents of the conversation match what was reported to the ADON. Resident #1 identified NA #1 could be heard yelling at, arguing with, and refusing to stop care and get the supervisor as he/she requested. Resident #1 identified he/she and his/her roommate were fearful of NA #1. In a written statement obtained by the facility of an interview on 3/3/25 with NA #1, NA #1 identified when she went into Resident #1's room the second time she told the resident that he/she was not the only resident there. NA #1 explained Resident #1 started going off on her and she said if you're going to go off, were going to go off together. In the statement NA #1 acknowledged it was not okay to raise her voice, and she should have excused herself and gotten a nurse to intervene. The facility Abuse Policy identified abuse or mistreatment of any kind toward a resident is strictly prohibited. Review of facility documentation identified that a Plan of Correction was initiated immediately: Staff training on Abuse and Neglect including Timely Reporting. Random audits on abuse and neglect, customer service, resident to staff interactions, care, and customer service will be conducted and will continue for a period of thirty (30) days or until substantial compliance is met. Audits to be reviewed at the monthly QAPI meetings. The Administrator or designee are responsible for the plan. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compliance as of 3/7/25. The plan of correction was reviewed on 3/26/25 and the facility met all components for past non-compliance.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident verbal abuse, the facility failed to report the allegation of verbal abuse to the Administrator and/or designee within two (2) hours after the event was reported by the resident to facility staff. The findings include: Resident #1's diagnoses included schizoaffective disorder, cognitive communication deficit, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had some memory recall deficits, had not exhibited behavioral symptoms, and was dependent on staff for toileting. The Facility Reported Incident form dated 3/2/25 identified at 3:40 PM Resident #1 reported having an interaction with an 11PM-7AM nurse aide, Nurse Aide (NA) #1, on 3/2/25 that upset him/her. Resident #1 requested that NA #1 no longer provides care for him/her. The nurse's note dated 3/3/25 at 2:02 PM identified the Social Worker and the Assistant Director of Nursing provided support to Resident #1 following a concern of staff to resident interaction. The note identified Resident #1 expressed concern regarding a nurse aide being argumentative on the prior overnight shift. Resident #1 reported staff had been supportive, he/she feels comfortable and safe at the time. The summary report dated 3/4/25 indicated on the 11PM- 7AM shift, 3/1/25 into 3/2/25, Resident #1 reported he/she had an interaction with NA #1 that he/she found upsetting and Resident #1 expressed concern about the way the situation was handled by NA #1. The report indicated the interaction did not reflect a level of professionalism and resident care that the facility expected from the team. NA #1 was suspended pending the investigation and then terminated. In a written statement dated 3/4/25 the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #2, identified on 3/2/25 sometime after 1:00 AM, NA #1 informed her that she was upset with Resident #1 because Resident #1 was rude and disrespectful, and Resident #1 requested to speak with the Nursing Supervisor. LPN #2 indicated she spoke with Resident #1 who appeared very upset and Resident #1 informed her of the altercation with NA #1. LPN #2 explained Resident #1 played the recorded audio for her. LPN #2 identified she provided care to Resident #1 the remainder of the shift and although she told NA #1 she was no longer to provide care to Resident #1, LPN #2 allowed NA #1 to provide care for others on her assignment. LPN #2 indicated she did not report the allegation to the Nursing Supervisor. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON) on 3/26/25 at 11:25 AM identified on 3/2/25 the 3PM-11PM Nursing Supervisor called her at approximately 3:00 PM to report that the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, told her she was made aware by a 3PM-11PM nurse aide, NA #2, that Resident #1 had an audio recording of an interaction that occurred between Resident #1 and NA #1 on 3/2/25 at approximately 2:00 AM. The ADON indicated she met with Resident #1 and listened to the recording which was very disturbing. The ADON indicated Resident #1 identified the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #2 had come into her room, listened to the recording of the incident that occurred and provided care to him/her. The ADON identified she spoke with LPN #2 and LPN #2 confirmed she was aware of the altercation, and she did not allow NA #1 to provide further services to Resident #1 that night. The ADON identified LPN #2 stated she did not report the incident to anyone because Resident #1 did not want it reported and LPN #2 allowed NA #1 to continue working the shift with other residents. The ADON identified LPN #2 should have informed the Nursing Supervisor and NA #1 should have been sent home immediately pending an investigation. The facility Abuse Policy identified abuse or mistreatment of any kind toward a resident must be reported to a supervisor immediately and the accused individual will be immediately suspended pending the outcome of the investigation. Review of facility documentation identified that a Plan of Correction was initiated immediately: Staff training on Abuse and Neglect including Timely Reporting. Random audits on abuse and neglect, customer service, resident to staff interactions, care, and customer service will be conducted and will continue for a period of thirty (30) days or until substantial compliance is met. Audits to be reviewed at the monthly QAPI meetings. The Administrator or designee are responsible for the plan. Compliance as of 3/7/25. The plan of correction was reviewed on 3/26/25 and the facility met all components for past non-compliance.