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	04/11/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **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 abuse, the facility failed to ensure the resident was free from misappropriation when a staff member obtained the resident's phone, gained account access, and transferred money. The findings include: Resident #1's diagnoses included acute respiratory failure with hypercapnia (when the body can't remove excess carbon dioxide from the bloodstream causing it to build up) and cognitive communication deficit. The Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented with good memory recall and required a two (2) person assist for transfers and ambulation and was independent with bed mobility and positioning. The baseline Resident Care Plan (RCP) dated 2/14/25 identified Resident #1 required assistance with Activities of Daily Living (ADLs). Interventions included utilizing a walker when ambulating. Review of the Resident Personal Possessions form dated 2/14/25 identified Resident #1 brought an iPhone and an iPad to the facility on admission. A nurse's note dated 2/16/25 at 4:08 AM identified Resident #1 was complaining of shortness of breath with noted oxygen levels between 71-72 percent (low oxygen level/body is not getting enough oxygen). The note identified that Emergency Medical Services (EMS) was called, and Resident #1 was transferred to the hospital Emergency Department (ED) for evaluation. Review of the facility Accident and Incident (A & I) report dated 3/19/25 identified the facility was notified by Resident #1's family member (Person #1) of unauthorized financial transactions made from Resident #1's personal cell phone to a PayPal account associated with a facility staff member's (NA #1) address and telephone number. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Summary Report dated 3/21/25 identified that on 2/16/25, Resident #1 was transferred to the hospital for an acute change in condition and his/her belongings, including his/her cell phone remained at the facility following the transfer. The report identified that the resident did not return to the facility, subsequently passing away in the hospital, and on 3/14/25, Person #1 came to the facility to retrieve Resident #1's belongings and reported Resident #1's cell phone to be missing. On 3/19/25, Person #1 contacted the facility and reported that he/she identified multiple unauthorized financial transactions originating from Resident #1's PayPal account. Person #1 identified there was a bank login alert on 3/17/25 which prompted him/her to access Resident #1's email where a series of PayPal withdrawals were discovered, dating from 2/19/25 through 3/17/25, totaling approximately $1735.00. Person #1 identified that the PayPal account in question was linked to an email and phone number which the facility verified matched a facility staff member (NA #1). The report identified that upon notification, the facility immediately initiated an internal investigation, the police were notified and the employee in question was suspended pending the outcome of the investigation. Interview with the DNS on 4/11/25 at 10:48 AM identified that following Person #1's report on 3/19/25 of unauthorized transactions on Resident #1's account associated/linked with NA #1's account, NA #1 was suspended pending an investigation. She identified that the facility had since been unable to contact NA #1, and reported he will no longer be employed by the facility. Review of NA #1's timecard identified that he worked the 11:00 PM to 7:00 AM shift on 2/14/25, 2/21/25, 2/22/25, 2/23/25, 2/27/25, 2/28/25, 3/4/25, 3/5/25, 3/7/25, 3/13/25 and 3/15/25. The timecard identified that he worked 7:09 AM to 11:04 PM on 2/17/25, 3:04 PM to 11:05 PM on 2/18/25, 7:08 AM to 3:20 PM on 2/19/25, 7:14 AM to 11:03 PM on 3/3/25, 3:02 PM to 11:00 PM on 3/17/25 and 3:10 PM to 10:59 PM on 3/18/25. Interview with Person #1 on 4/11/25 at 10:55 AM identified that he/she was Resident #1's financial Power of Attorney (POA) and reported Resident #1's personal bank account security reset was linked to his/her (Person #1's) phone. Person #1 indicated that on 3/17/25, he/she received a text with a code to sign into Resident #1's bank account. Person #1 identified when he/she (Person #1) signed into the account there was only about $500 left in the account, and the balance was usually between $2,000 and $6,000 depending on the time of the month. Person #1 identified he/she noticed numerous withdrawals from Resident #1's personal PayPal account. Person #1 identified that he/she was unable to gain access to Resident #1's PayPal account, so accessed Resident #1's email where he/she observed numerous emails associated with PayPal transactions that were made. She identified that fraudulent charges included: $108 on 2/19/25, $100 on 2/24/25, $377 on 3/6/25, $550 on 3/12/25, $550 on 3/17/25 and $50 on 3/17/25. Person #1 then withdrew all remaining funds from the bank account after filing a police report on 3/18/25. Person #1 reported that although not all the transfers were identified in Resident #1's email, he/she was able to locate an email showing a transfer of $200 was sent to NA #1 from Resident #1 on 3/15/25 and another email with a transfer of $200 was sent to Person #2 with NA #1's phone number on 3/17/25. Person #1 identified that he/she was unsure who Person #2 was but that there was a NA with Person #2's last name who worked at the facility. Person #1 indicated he/she never reported Person #2 to the facility. Additionally, Person #1 identified that a letter was received and identified a PayPal credit card was requested in Resident #1's name but was denied because Resident #1's identity was not confirmed. Further, an email was received on 3/17/25 stating that the PayPal account billing address for Resident #1 was changed to NA #1's address. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility schedule dated 2/15/25 identified NA #3 was scheduled to work the 11:00 PM to 7:00 AM shift on 2/15/25 at the facility. Interview with the DNS on 4/11/25 at 11:25 AM identified that NA #3 was terminated prior to the misappropriation allegation on 3/19/25 for attendance issues. She indicated there were no reports made to her of a connection between NA #3 and the allegation. Review of NA #3's personnel file identified his address matched that of NA #1. Review of NA #3's timecard identified he worked the 3:00 PM to 11:00 PM shift on 2/17/25, 2/19/25, 2/20/25, 2/22/25, 2/23/25, 2/24/25, 2/26/25, 2/27/25, 3/3/25, 3/5/25, 3/6/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25 and 3/17/25. He worked the 11:00 PM to 7:00 AM shift on 3/15/25. Interview with NA #3 on 4/11/25 at 12:15 PM identified that he did not have recent contact with NA #1 and reported that he never stole from a resident or been involved with misappropriation of resident property or money. He identified that the phone number associated with Person #2's name was NA #1's phone number. Interview with Administrator #2 (previous Administrator) on 4/11/25 at 1:44 PM identified she was unaware NA #3 was involved in the allegation. Administrator #2 indicated that other staff, residents and their representatives were not interviewed to ensure other residents were not affected but stated those interviews should have been conducted. Administrator #2 identified that the misappropriation of Resident #1's money should not have occurred. Although attempted, an interview with NA #1 was not obtained. Review of the Abuse policy (undated) directed, in part, that abuse or mistreatment of any kind towards a resident is strictly prohibited. Any allegation of abuse by a staff member, visitor, family member, or resident must be reported immediately to a facility supervisor. All allegations will be thoroughly investigated, and appropriate action will be taken. Misappropriation of resident property is defined as the deliberate misuse, exploitation, or theft of a resident's belongings or money without consent. Any staff member witnessing or suspecting abuse must immediately report it to a supervisor who should then immediately notify the Director of Nursing (DNS) and the Administrator. An A & I report will be completed for each resident involved. Nursing staff will document a description of the incident in the resident's record. The DNS or designee will notify the resident's family, physician, Department of Public Health and local police as needed. The Administrator/DNS or designee will initiate an investigation and submit an online report to the Facility Licensing and Investigation Section (FLIS) within two (2) hours of notification. The accused individual will be immediately suspended pending the outcome of the investigation. The investigation will include: Interviews with all witnesses, including the accused, interviews with any individuals with relevant information, signed and dated statements from all involved parties and review of the accused staff member's employment record.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **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 abuse, the facility failed to fully investigate an allegation of misappropriation of money to include obtaining statements from the accused, other staff, other residents and/or resident representatives to ensure all residents were free from misappropriation in accordance with facility policy. The findings include: Resident #1's diagnoses included acute respiratory failure with hypercapnia (when the body can't remove excess carbon dioxide from the bloodstream causing it to build up) and cognitive communication deficit. The Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented with good memory recall and required a two (2) person assist for transfers and ambulation and was independent with bed mobility and positioning. The baseline Resident Care Plan (RCP) dated 2/14/25 identified Resident #1 required assistance with Activities of Daily Living (ADLs). Interventions included utilizing a walker when ambulating. Review of the Resident Personal Possessions form dated 2/14/25 identified Resident #1 brought an iPhone and an iPad to the facility on admission. A nurse's note dated 2/16/25 at 4:08 AM identified Resident #1 was complaining of shortness of breath with noted oxygen levels between 71-72 percent (low oxygen level/body is not getting enough oxygen). The note identified that Emergency Medical Services (EMS) was called, and Resident #1 was transferred to the hospital Emergency Department (ED) for evaluation. Review of the facility Accident and Incident (A & I) report dated 3/19/25 identified the facility was notified by Resident #1's family member (Person #1) of unauthorized financial transactions made from Resident #1's personal cell phone to a PayPal account associated with a facility staff member's (NA #1) address and telephone number. Review of the facility Summary Report dated 3/21/25 identified that on 2/16/25, Resident #1 was transferred to the hospital for an acute change in condition and his/her belongings, including his/her cell phone remained at the facility following the transfer. The report identified that the resident did not return to the facility, subsequently passing away in the hospital, and on 3/14/25, Person #1 came to the facility to retrieve Resident #1 ' s belongings and reported Resident #1's cell phone to be missing. On 3/19/25, Person #1 contacted the facility and reported that he/she identified multiple unauthorized financial transactions originating from Resident #1 ' s PayPal account. Person #1 identified there was a bank login alert on 3/17/25 which prompted him/her to access Resident #1's email where a series of PayPal withdrawals were discovered, dating from 2/19/25 through 3/17/25, totaling approximately $1735.00. Person #1 identified that the PayPal account in question was linked to an email and phone number which the facility verified matched a facility staff member (NA #1). The report identified that upon notification, the facility immediately initiated an internal investigation, the police were notified and the employee in question was suspended pending the outcome of the investigation. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/11/25 at 10:48 AM identified that following Person #1's report on 3/19/25 of unauthorized transactions on Resident #1's account associated/linked with NA #1 ' s account, NA #1 was suspended pending an investigation. She identified that the facility had since been unable to contact NA #1 and reported he will no longer be employed by the facility. Review of NA #1's timecard identified that he worked the 11:00 PM to 7:00 AM shift on 2/14/25, 2/21/25, 2/22/25, 2/23/25, 2/27/25, 2/28/25, 3/4/25, 3/5/25, 3/7/25, 3/13/25 and 3/15/25. The timecard identified that he worked 7:09 AM to 11:04 PM on 2/17/25, 3:04 PM to 11:05 PM on 2/18/25, 7:08 AM to 3:20 PM on 2/19/25, 7:14 AM to 11:03 PM on 3/3/25, 3:02 PM to 11:00 PM on 3/17/25 and 3:10 PM to 10:59 PM on 3/18/25. Interview with Social Worker #1 (Director of Social Services) and Social Worker #2 on 4/11/25 at 10:34 AM identified they were not involved in the investigation regarding NA #1 and that Resident #1 was no longer in the facility when the allegations were made. They indicated they were made aware of the allegations but were not provided a timeline or instructed to assist in the investigation or conduct interviews. They identified they had no reports of expensive missing items between February and March 2025, only reports of missing clothing. Interview with Person #1 on 4/11/25 at 10:55 AM identified that he/she was Resident #1's financial Power of Attorney (POA) and reported Resident #1's personal bank account security reset was linked to his/her (Person #1's) phone. Person #1 indicated that on 3/17/25, he/she received a text with a code to sign into Resident #1's bank account. Person #1 identified when he/she (Person #1) signed into the account there was only about $500 left in the account, and the balance was usually between $2,000 and $6,000 depending on the time of the month. Person #1 identified he/she noticed numerous withdrawals from Resident #1 ' s personal PayPal account. Person #1 identified that he/she was unable to gain access to Resident #1's PayPal account, so accessed Resident #1 ' s email where he/she observed numerous emails associated with PayPal transactions that were made. She identified that fraudulent charges included: $108 on 2/19/25, $100 on 2/24/25, $377 on 3/6/25, $550 on 3/12/25, $550 on 3/17/25 and $50 on 3/17/25. Person #1 then withdrew all remaining funds from the bank account after filing a police report on 3/18/25. Person #1 reported that although not all the transfers were identified in Resident #1's email, he/she was able to locate an email showing a transfer of $200 was sent to NA #1 from Resident #1 on 3/15/25 and another email with a transfer of $200 was sent to Person #2 with NA #1's phone number on 3/17/25. Person #1 identified that he/she was unsure who Person #2 was but that there was a NA with Person #2's last name who worked at the facility. Person #1 indicated he/she never reported Person #2 to the facility. Additionally, Person #1 identified that a letter was received and identified a PayPal credit card was requested in Resident #1's name but was denied because Resident #1's identity was not confirmed. Further, an email was received on 3/17/25 stating that the PayPal account billing address for Resident #1 was changed to NA #1's address. Review of the facility schedule dated 2/15/25 identified NA #3 was scheduled to work the 11:00 PM to 7:00 AM shift on 2/15/25. Interview with the DNS on 4/11/25 at 11:25 AM identified that NA #3 was terminated prior to the misappropriation allegation on 3/19/25 for attendance issues. She indicated there were no reports made to her of a connection between NA #3 and the allegation. Review of NA #3's personnel file identified his address matched that of NA #1. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of NA #3's timecard identified he worked the 3:00 PM to 11:00 PM shift on 2/17/25, 2/19/25, 2/20/25, 2/22/25, 2/23/25, 2/24/25, 2/26/25, 2/27/25, 3/3/25, 3/5/25, 3/6/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25 and 3/17/25. He worked the 11:00 PM to 7:00 AM shift on 3/15/25. Interview with NA #3 on 4/11/25 at 12:15 PM identified that he did not have recent contact with NA #1 and reported that he never stole from a resident or been involved with misappropriation of resident property or money. He identified that the phone number associated with Person #2's name was NA #1's phone number. Interview with Administrator #2 (previous Administrator) on 4/11/25 at 1:44 PM identified she was unaware NA #3 was involved in the allegation. Administrator #2 indicated that other staff, residents and their representatives were not interviewed to ensure other residents were not affected but stated those interviews should have been conducted. Administrator #2 identified that the misappropriation of Resident #1's money should not have occurred. Interview with the DNS on 4/11/25 at 2:51 PM identified that a full investigation regarding the 3/19/25 allegation of misappropriation should have been completed to include interviews with other staff, residents and their representatives. The DNS indicated interviews were not conducted because the allegation was made a month after the alleged misappropriation and the residents and their families on Resident #1's unit were involved and vocal, and she assumed they would report anything missing. Although attempted, an interview with NA #1 was not obtained. Review of the Abuse policy (undated) directed, in part, that abuse or mistreatment of any kind towards a resident is strictly prohibited. Any allegation of abuse by a staff member, visitor, family member, or resident must be reported immediately to a facility supervisor. All allegations will be thoroughly investigated, and appropriate action will be taken. Misappropriation of resident property is defined as the deliberate misuse, exploitation, or theft of a resident's belongings or money without consent. Any staff member witnessing or suspecting abuse must immediately report it to a supervisor who should then immediately notify the Director of Nursing (DNS) and the Administrator. An A & I report will be completed for each resident involved. Nursing staff will document a description of the incident in the resident's record. The DNS or designee will notify the resident's family, physician, Department of Public Health and local police as needed. The Administrator/DNS or designee will initiate an investigation and submit an online report to the Facility Licensing and Investigation Section (FLIS) within two (2) hours of notification. The accused individual will be immediately suspended pending the outcome of the investigation. The investigation will include: Interviews with all witnesses, including the accused, interviews with any individuals with relevant information, signed and dated statements from all involved parties and review of the accused staff member's employment record.

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for personal care and assistance, the facility failed to ensure documentation was complete in the clinical record. The findings include: Resident #2's diagnoses included type 2 diabetes mellitus with hyperglycemia (elevated blood sugar levels), congestive heart failure (when the heart cannot pump blood efficiently enough to give your body a normal supply), obesity and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderately impaired cognition and required setup assistance with eating, substantial assistance with toileting hygiene, showering/bathing self, personal hygiene, bed mobility and transfers. Additionally, it identified that Resident #1 had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) and was occasionally incontinent of bowel. The Resident Care Plan (RCP) dated 3/25/25 identified Resident #2 required assistance with Activities of Daily Living (ADLs) due to a history of falls, Acute Kidney Injury (AKI) and chronic first thoracic (T1) fracture (topmost vertebrae in the thoracic spine). Interventions included to offer assistance as needed with washing, bathing, dressing, toileting and oral hygiene, offer comfort bath/bed bath if the resident refuses a bath/shower, offer the resident assistance with tasks that they are unable to complete and provide assistance as ordered with transfers, ambulation and toileting. Review of the March 2025 Documentation Survey Report (Nurse Aide Documentation) for Resident #2 failed to identify documentation every shift on: a. Bladder elimination on 3/3/25, 3/4/25, 3/8/25 through 3/14/25, 3/17/25, 3/19/25 and 3/23/25 through 3/26/25. b. Bowel elimination on 3/3/25, 3/4/25, 3/8/25 through 3/10/25, 3/12/25 through 3/14/25, 3/17/25, 3/19/25 and 3/23/25 through 3/26/25; c. Eating on 3/4/25, 3/5/25, 3/8/25 through 3/10/25, 3/12/25 through 3/14/25, 3/19/25 and 3/24/25 through 3/26/25; d. Personal hygiene on 3/4/25, 3/5/25, 3/8/25 through 3/10/25, 3/12/25 through 3/14/25, 3/19/25 and 3/24/25 through 3/26/25. e. Showering/bathing self on 3/3/25, 3/4/25, 3/8/25 through 3/10/25, 3/12/25 through 3/14/25, 3/19/25 and 3/24/25 through 3/26/25. f. Toileting hygiene on 3/3/25, 3/4/25, 3/8/25 through 3/10/25, 3/12/25 through 3/14/25, 3/19/25 and 3/24/25 through 3/26/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Amount eaten on 3/3/25, 3/4/25, 3/8/25 through 3/10/25, 3/12/25 through 3/14/25, 3/19/25 and 3/24/25 through 3/26/25. h. Bowel and Bladder diary on 3/4/25 through 3/6/25, 3/8/25 through 3/10/25 and 3/12/25 through 3/14/25. i. Fluid intake on 3/19/25 and 3/23/25 through 3/26/25. j. Output on 3/19/25 and 3/23/25 through 3/26/25. A nurse's note dated 3/29/25 at 4:01 PM identified that Resident #2 was unable to hold the phone per his/her baseline. The note reported that a blood pressure was obtained and was high, blood sugar was normal, skin was pale and cool to touch and the resident was unable to respond verbally to staff regarding how he/she felt. The APRN was notified, and an order was obtained to transfer the resident to the Emergency Department for evaluation. Review of facility census identified that Resident #2 did not return to the facility. Interview with the DNS on 4/11/25 at 1:25 PM identified that it is expected that the Nurse Aides (NA's) are documenting on every resident, every shift, or as directed in the electronic medical record. She identified that NA compliance with consistent documentation was a work in progress and she is continuing to educate staff as she identifies missing documentation. Review of the CNA Flow Sheets (Resident Care Record) policy dated 05/2023 directed, in part, that the resident flow sheet will be completed nearest to the end of the shift as possible by the Certified Nursing Assistant (CNA) assigned to the resident. The following guide must be followed: Each resident in the facility will have a new flow sheet initiated by the CNA in Point Click Care (electronic health record), the flow sheet will have the resident's name, month, year and date, the CNA will document the care provided to the resident for that shift by completing the entire flow sheet, all the approved coding and abbreviations shall be used and upon completion each CNA must initial in the appropriate box. The flow sheet is a part of the resident's medical record in Point Click Care. The CNA flow sheet will be used to assist in developing an individualized plan of care for the resident.