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	04/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 documentation, facility policy and interviews for one (1) of four (4) residents (Residents #1, 2, 3 and 4) reviewed for resident-to-resident abuse, the facility failed to ensure the residents were monitored for injuries, mood and behaviors after resident-to-resident abuse incidents. The findings include: 1. Resident #1's diagnoses included vascular dementia, anxiety disorder, history of a traumatic brain injury and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicative of severely impaired cognition and was independent with bed mobility, transfers and ambulation. The MDS identified Resident #1 exhibited no behaviors. The Resident Care Plan (RCP) dated 10/21/24 identified Resident #1 was involved in a resident-to-resident altercation on 10/21/24 and he/she hit another resident in the face. Interventions included completing a Registered Nurse (RN) assessment, administering medications per physician's orders, offering psychiatric support and services, social services to follow-up and offer support, monitoring Resident #1 for signs of mental distress, increased anxiety, change in mood state and reporting to the provider, and if signs of increased agitation, anxiety and/or mood changes were identified, provide Resident #1 with emotional support. Review of the facility Reportable Event (RE) dated 10/21/24 identified that at 2:30 PM Resident #1 was agitated with Resident #2 yelling in the hallway and Resident #1 subsequently went out into the hallway and struck Resident #2 on the left side of the face with a closed fist. The RE identified both Resident #1 and Resident #2 were separated, the Advanced Practice Registered Nurse (APRN) was notified, the responsible party was notified and the psychiatric APRN was in-house and met with Resident #1 and ordered Trazodone 25 milligrams (mg) every six (6) hours as needed for anxiety for fourteen (14) days. The intervention included emotional support to be provided by social services, psychiatric support and services and identified that the facility would monitor Resident #1 for mood and behaviors and redirect Resident #1 as needed. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A psychiatric Advanced Practice Registered Nurse (APRN) note dated 10/21/24 identified she evaluated Resident #1 following an altercation with another resident. The note reported Resident #1 denied worsening mood concerns but directed to monitor for emergence. The note identified Resident #1 denied worsening anxiety but indicated Resident #1 presented mildly anxious secondary to the interaction, would order trazodone as needed, directed to monitor for changes in cognition, provide support/reassurance as needed and redirect Resident #1 as tolerated. Review of physician's orders for October 2024 failed to identify an order for monitoring of the resident's behaviors or mood. Review of the October 2024 Medication Administration Record (MAR) failed to identify mood or behavior monitoring for Resident #1. Review of nurses notes from 10/21/24 through 10/24/24 failed to identify any documentation of Resident #1's mood or behavior on the 3:00 PM to 11:00 PM shift on 10/21/24, the 11:00 PM to 7:00 AM shift on 10/21/24, the 3:00 PM to 11:00 PM shift on 10/22/24, the 11:00 PM to 7:00 AM shift on 10/22/24 or the 11:00 PM to 7:00 AM shift on 10/23/24 following the resident-to-resident incident. 2. Resident #2's diagnoses included vascular dementia with mood disturbances, generalized anxiety disorder, other specified depressive episodes and chronic myeloid leukemia (an uncommon slowly progressing blood-cell cancer that begins in the bone marrow). The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of six (6) indicative of severely impaired cognition and required supervision assistance for ambulation and substantial assistance for transfers. The Resident Care Plan (RCP) dated 10/21/24 identified Resident #2 was involved in a resident-to-resident altercation on 10/21/24 when he/she was hit in the face by another resident. Interventions included completing a Registered Nurse (RN) assessment, a body audit/skin check as needed, offering psychiatric support and services, social services to follow-up and offer support, monitoring Resident #2 for signs of mental distress, increased anxiety and change in mood state, and reporting to the provider and if signs of increased agitation, anxiety or if making inappropriate statements to staff/residents was identified, provide Resident #2 with emotional support. Review of the facility Reportable Event (RE) dated 10/21/24 identified that at 2:30 PM Resident #2, who was yelling in the hallway, was struck by Resident #1, on the left side of the face, with a closed fist. The RE identified that both Resident #1 and Resident #2 were separated, the APRN was notified, the responsible party was notified and the psych APRN was in-house and met with the resident and ordered Trazodone 25 milligrams (mg) every six (6) hours as needed for anxiety for fourteen (14) days. The intervention included emotional support to be provided by social services, psychiatric support and services and identified that the facility would monitor Resident #2 for mood and behaviors and Resident #2's skin would be monitored for any discoloration at the site of the impact. A psychiatric Advanced Practice Registered Nurse (APRN) note dated 10/21/24 identified she evaluated Resident #2 following an altercation with another resident, Resident #2 denied any anxiety or distress and stated he/she felt safe in the facility following the incident. The note identified that due to intermittent behavioral disturbance and anxiety, trazodone would be ordered as needed, directed to provide support/reassurance as needed and redirect Resident #2 as tolerated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician's orders for October 2024 failed to identify orders for monitoring Resident #2's mood or monitoring Resident #2's skin for any discoloration at the site of the impact. Review of the October 2024 Medication Administration Record (MAR) failed to identify monitoring of Resident #2's mood or monitoring of Resident #2's skin for any discoloration at the site of the impact. Review of nurses notes from 10/21/24 through 10/24/24 failed to identify any documentation of Resident #2's mood or documentation of Resident #2's skin on the 11:00 PM to 7:00 AM shift on 10/22/24 or the 11:00 PM to 7:00 AM shift on 10/23/24 following the resident-to-resident incident. 3. Resident #3's diagnoses included vascular dementia, anxiety, restlessness and agitation and atrial fibrillation (an irregular and often very rapid heart rhythm). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of four (4) indicative of severely impaired cognition and required supervision assistance for bed mobility and ambulation and substantial assistance for transfers. The MDS identified Resident #3 exhibited no behaviors. The Resident Care Plan (RCP) dated 10/26/24 identified Resident #3 was involved in a resident-to-resident altercation on 10/26/24 when he/she hit another resident in the face. Interventions included completing a Registered Nurse (RN) assessment, offering psychiatric support and services, social services to follow-up and offer support, monitoring Resident #3 for signs of mental distress, increased anxiety and change in mood state and report to the provider and if signs of increased agitation, anxiety and/or mood changes were identified, provide Resident #3 with emotional support. Review of the facility Reportable Event (RE) dated 10/26/24 identified that at 4:30 PM Resident #3 allegedly stated there was a fire in the room, that Resident #4 (roommate) needed to get out of the way, and then Resident #3 slapped Resident #4 in the face, which was unwitnessed and reported by Resident #4. The RE identified that both Resident #3 and Resident #4 were separated, the Advanced Practice Registered Nurse (APRN) was notified and recommended Resident #3 be evaluated by psychiatric services and the responsible party was notified of the event. The interventions included a room change for Resident #3, emotional support to be provided by social services, psychiatric support and services and identified that the facility would monitor Resident #3 for mood and behaviors. A psychiatric Advanced Practice Registered Nurse (APRN) note dated 10/28/24 identified she evaluated Resident #3 following an altercation with another resident. The note reported Resident #3 had no memory of the incident but was noted to have an increase in anxiety and intermittent episodes of impulsivity and was reporting poor sleep. The APRN identified she was going to trial Remeron 7.5 milligrams (mg) daily at bedtime for anxiety/sleep/poor intake, directed to provide Resident #3 with support and reassurance, and redirect as needed. Review of physician's orders for October 2024 failed to identify an order for monitoring Resident #3's behaviors or mood. Review of the October 2024 Medication Administration Record (MAR) failed to identify mood or behavior monitoring for Resident #3. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurses notes from 10/26/24 through 10/29/24 failed to identify any documentation on Resident #3's mood or behavior on the 11:00 PM to 7:00 AM shift on 10/26/24, the 7:00 AM to 3:00 PM shift on 10/27/25, the 3:00 PM to 11:00 PM shift on 10/27/24, the 11:00 PM to 7:00 AM shift on 10/27/24, the 11:00 PM to 7:00 AM shift on 10/28/24, the 7:00 AM to 3:00 PM shift on 10/29/24 or the 3:00 PM to 11:00 PM shift on 10/29/24 following the resident-to-resident incident. 4. Resident #4's diagnoses included anxiety disorder, mild cognitive impairment and other specified depressive episodes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required supervision assistance for transfers and substantial assistance for ambulation. The Resident Care Plan (RCP) dated 10/26/24 identified Resident #4 was involved in a resident-to-resident altercation on 10/26/24 when he/she was hit in the face by another resident. Interventions included completing a Registered Nurse (RN) assessment, a body audit/skin check as needed, offering psychiatric support and services and social services to follow-up and offer support. Review of the facility Reportable Event (RE) dated 10/26/24 identified that at 4:30 PM Resident #4 came out of his/her room and reported to staff that Resident #3 stated there was a fire in their room and that Resident #4 (roommate) needed to get out of the way and then Resident #3 slapped him/her (Resident #4) in the face, which was unwitnessed. The RE identified that both Resident #3 and #4 were separated, the Advanced Practice Registered Nurse (APRN) was notified and recommended Resident #4 was evaluated by psychiatric services and the responsible party was notified of the event. The interventions included emotional support to be provided by social services, psychiatric support and services and identified that the facility would monitor Resident #4 for mood and behaviors and Resident #4's skin would be monitored for any discoloration at the site of the impact. A psychiatric Advanced Practice Registered Nurse (APRN) note dated 10/29/24 identified she evaluated Resident #4 following an altercation with another resident, Resident #4 denied anxiety or distress and stated he/she felt safe in the facility following the incident. The note identified that no medication changes were indicated and directed to monitor for the emergence of anxiety. Review of physician's orders for October 2024 failed to identify orders for monitoring of Resident #4's mood and behaviors or monitoring of Resident #4's skin for any discoloration at the site of the impact. Review of the October 2024 Medication Administration Record (MAR) failed to identify monitoring of Resident #4's mood or behaviors, or monitoring of Resident #4's skin for any discoloration at the site of the impact. Review of nurses notes from 10/26/24 through 10/29/24 failed to identify any documentation on Resident #4's mood or behaviors or documentation on Resident #4's skin on the 11:00 PM to 7:00 AM shift on 10/26/24 or the 11:00 PM to 7:00 AM shift on 10/27/24 following the resident-to-resident incident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 4/30/25 at 1:28 PM identified that for all resident-to-resident incidents, nursing staff should monitor, assess and document mood, behavior, resident's skin and any subsequent injuries for all residents involved, every shift, for 72 hours. She reported she was unaware monitoring and documentation was not completed consistently for Residents #1, #2, #3 and #4 and indicated she did education with the 11:00 PM to 7:00 AM shift nurses a few weeks prior, after identifying documentation was not being completed consistently, but further identified she did not document the education or complete audits. Review of the Resident-to-Resident Abuse policy dated (undated) directed, in part, identified that abuse of any kind between residents, including physical will not be tolerated. All residents have the right to feel safe, respected and free from harm while residing in the facility. Staff will observe interactions and intervene as necessary. The safety and well-being of residents will be prioritized. Allegations will be reviewed promptly and appropriate action taken, which may include medications, separation of residents, increased supervision, behavioral interventions or referrals for outside support. Affected residents may be offered access to clinical, medical, or supportive services including counseling as needed. Staff will monitor future interactions to help prevent recurrence.