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	03/14/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 resident (Resident #16) reviewed for care planning, the facility failed to conduct an interdisciplinary care conference at least quarterly with the resident representative. The findings include: Resident #16 was admitted to the facility with diagnoses which included Alzheimer's disease and dementia. The significant change of condition MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, was frequently incontinent of bladder and always incontinent of bowel and required extensive assistance with bed mobility, toileting, and personal hygiene. Additionally, required limited assistance with transfers, dressing, and locomotion on and off the unit. The care plan dated 8/11/23 identified Resident #16 had Alzheimer's and needed long term care. Interventions included to continue to keep his/her facility involved and updated regarding his/her health and well-being. Interview with the resident representative (Person #1) on 3/7/24 at 1:17 PM indicated she does not have a quarterly meeting with the interdisciplinary team to review Resident #16's plan of care he/she only gets a phone call from SW #2 every 3 months, and they discuss Resident #16's care together. Person #1 indicated he/she cannot recall a meeting with the whole team occurring in at least the last year he/she only meets with the social worker. (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

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 03/14/2024
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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with SW #2 on 3/12/24 at 11:54 AM the MDS department was responsible to distribute a monthly calendar of which residents were to have a care plan meeting on which days and notify the resident representatives. SW #2 indicates it was her responsibility to hold the meetings in her office or in a resident room if the resident had requested it. SW #2 indicated the IDT (interdisciplinary team) includes the therapy department, social services, dietary, recreation and MDS. SW #2 indicated she tries to meet with the IDT but usually it is just the social worker, and she calls the resident representative on a quarterly basis. SW #2 indicated she does call the resident representative and provides him/her updates via the phone for the quarterly meeting since Covid and gives any updates from the other departments if they ask her to. SW #2 indicated they try to have the IDT meet but usually it is just social work. SW #2 indicated that the social worker was responsible for putting in a progress note for the care conference meetings, but she has not had time to put notes in the electronic medical record. SW #2 indicated there were not any progress notes from the care conference meetings. Interview with RN #3 (MDS coordinator) on 3/12/24 at 12:00 PM indicated that she was responsible to schedule the admission, quarterly, annual and change in condition MDS's and resident care conferences. RN #3 indicated that she mails out the invites to the families and recreation gives the residents the invites. RN #3 indicated that everyone that attends the meeting should sign in on the care conference form. RN #3 indicated that if a department does not attend the meeting, she allows them to sign the sign in sheet to indicate that they had updated their section of the care plan and that they had done their assessments. RN #3 indicated that the different departments can sign off on the sign in sheet for the care conferences even though they did not attend the meeting. Review of the sign in sheet dated 10/3/22, 1/31/23, 4/13/23, 5/16/23, 8/11/23, 8/31/23, 11/21/23, and 2/27/24, RN #3 indicated that resident representative attended but there were no signatures. RN #3 indicated that if the resident representative was in attendance the expectation was the resident representative would have signed the form. RN #3 indicated when she wrote attended in the resident representative spaces it may have been a phone conference. RN #3 indicated she did not know who attended the meetings because if the staff did the care plan and assessments, they were allowed to sign the attendance sheet. RN #3 indicated that the social workers were responsible for putting in resident care plan meeting notes about the meeting and who attended. RN #3 indicated that she needed to start writing if it was a conference call if the person was present have them sign the form. RN #3 indicated if the department does not attend, she will not allow them to sign the form. Review of the facility Care Planning Policy identified a comprehensive and individualized plan of care will be developed for each resident. The care plan will guide caregivers to assist residents in achieving or maintaining their highest level of wellbeing. The care plan is developed by the Interdisciplinary Team (IDT) in collaboration with the resident and/or the resident representative and the resident's physician. The IDT may include but is not limited to the MDS coordinator, charge nurse, nursing assistant, Dietary Manager or Dietitian, Social Worker, Rehab Therapist, and Activities Director. A care conference is to discuss the plan of care and will be held on or before day 21 from admission and then at least quarterly. The resident and/or resident representative will be invited to attend all care plan conferences. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility Resident [NAME] of Rights Policy identified the resident has the right to participate in planning their care and treatment, to identify individuals they want included in the care planning process, to be fully informed of the care to be provided and the caregivers who will be providing the care and be informed in advance about changes in their care and treatment. The resident has the right to request revisions to their care plan, to request care plan meetings and to sign the plan of care after significant changes are made.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility policy, and interviews for 2 of 26 residents (Resident #43 and Resident #315) reviewed for advance directives, the facility failed to accurately document the resident's life support choices and/or failed to ensure advanced directives were reviewed with a newly admitted resident. The findings include: 1. Resident #43 was admitted to the facility on [DATE] with diagnoses which included enterocolitis due to clostridium difficile, hemiplegia and hemiparesis following cerebrovascular disease, and heart failure. The signed advance directive consent form dated [DATE] identified the conservator of Resident #43's choice regarding life support systems elected for Resident #43 to receive cardiopulmonary resuscitation (CPR). The admission MDS assessment dated [DATE] identified Resident #43 had severely impaired cognition. The hospital discharge summary dated [DATE] identified Resident #43 was admitted to the hospital on [DATE]; on [DATE] a meeting was held with representatives from the hospital's medical and palliative care services and Resident #43's conservator, via telephone. Resident #43's conservator had come to a consensus with the family to change Resident #43's code status to do not resuscitate (DNR). Resident #43 was amenable to this plan (communication and understanding were somewhat limited by the patient's history of cerebrovascular accident (CVA) but he/she was able to nod emphatically when the details of the care plan were discussed). Resident #43's conservator indicated that he/she would review the applicable documentation and get back to the representative with a time to return and complete it in person. Resident #43 was readmitted to the facility on [DATE]. A physician's order dated [DATE] directed Resident #43's code status was a DNR. The signed advance directive consent form dated [DATE] identified the conservator of Resident #43's choice regarding life support systems elected Resident #43's code status be changed to DNR/DNI. Interview and clinical record review with SW #1 on [DATE] at 4:37 PM identified that during Resident #43's January admission to the hospital a meeting with the palliative care team took place with his/her conservator. SW #1 indicated that according to the hospital's documentation Resident #43's family had become more interested in changing Resident #43's code status to DNR/DNI and that the hospital staff offered to assist the conservator with filling out the appropriate documentation to assure Resident #43 and the family's wishes regarding advance directives were followed. SW #1 further indicated, if she remembered correctly, Resident #43's conservator did not change Resident #43's code status from CPR to DNR prior to his/her readmission to the facility, as the conservator was still discussing the advance directive options with the family. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on [DATE] at 8:17 AM identified that when Resident #43 returned from the hospital on [DATE] a physician's order was put into the resident's electronic health record for a DNR code status, by the admitting nurse, but the advance directive consent form was not signed by the conservator until [DATE]. The DNS indicated that there should not be a time gap from the advance directive consent form being signed and physician's advance directive orders being entered into the resident's clinical record. The DNS identified that while the hospital discharge instructions indicated that the palliative team recommended that Resident #43's code status be changed to a DNR, the code status in Resident #43's electronic health record should not have been changed until the facility was able to contact Resident #43's conservator and confirm that he/she consented to the DNR/DNI. The DNS indicated that a telephone consent could have been obtained from Resident #43's conservator with 2 nurses as a witness if they were not able to obtain a timely in-person consent. Although attempted, an interview with the admitting nurse (RN #5) was not obtained. The Advance Directives policy directs the health care provider and/or resident's attending physician will review advance directives with the capable resident or the appropriate substitute decision maker(s). The plan of care related to advance directives and withholding/withdrawing life sustaining treatment will be documented on resident's advance directive consent form and physician's orders. The form will be signed and dated by the person who reviewed the advance directive with the resident or decision maker(s), and the person who consented to the advance directives. A physician's order will be obtained related to the resident's advance directives and refusal of treatment. It the resident or substitute decision maker(s) does not execute an advance directive; the resident will be a full code until a decision is made by the resident or substitute decision maker. 2. Resident # 315 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection, history of falls, and hypertension. Review of the clinical record identified an admission checklist dated [DATE] for Resident #315. The checklist identified that the facility had not reviewed code status and consent with Resident #315 with and that follow up items were needed including that advance directives and consents required signatures. The checklist also identified that code status review and consent were a must complete admission item. The care plan dated [DATE] identified Resident #315 needed assistance with ADLs due to weakness following a recent hospitalization . Interventions included advance directives per resident. The admission MDS assessment dated [DATE] identified Resident # 315 had intact cognition, was always incontinent of bladder and required the assistance of two staff members with transfers, toileting, and was independent with eating. Review of the clinical record on [DATE] identified multiple blank admission documents in Resident #315's paper chart, which included release and consent for treatment at the facility, consent and authorization for treatment with facility contracted mental health provider, and informed consent for wound care consultation and treatment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #315 on [DATE] at 11:55AM identified he/she had not reviewed any information with facility staff related to advance directives and had not signed any documents since admission to the facility. Review of the clinical record and interview with LPN #1 on [DATE] at 12:30 PM identified she was aware that Resident #315 did not have any documentation related to signed advance directives in the clinical record. LPN #1 identified that it was the responsibility of the nurse admitting the resident to the facility to ensure all the admission documentation was completed, including advance directives. When asked what the staff did in the event the advance directive paperwork or any other admission documentation was not completed, LPN #1 reiterated it was the responsibility of the admitting nurse for the resident to complete outstanding admission documentation. Interview with RN # 1 on [DATE] at 12:34 PM identified that all admission paperwork should be completed when the resident is admitted by the admitting nurse, but that it was the responsibility of the nursing staff to ensure it was completed. Subsequent to surveyor inquiry, the facility reviewed and obtained signatures on all admission documents, including advance directives and all consents for treatment, from Resident #315 on [DATE]. Review of the clinical record and interview with the DNS on [DATE] at 1:54 PM identified that all residents of the facility should have an admission packet and checklist reviewed and completed by the admitting nurse. The DNS identified that the admitting nurse was usually the RN supervisor, and if the RN supervisor was not able to complete the admission paperwork, it would be delegated to any nurse available to complete the paperwork or handed off the to the oncoming RN supervisor. The DNS identified that while it was the responsibility of the admitting nurse to complete the admission documentation, including review and consents related to advance directives, any nurse caring for Resident #315 could and should have reviewed advance directives to ensure his/her choices. The facility policy on advance directives directed that the resident would be provided the policy and education on advance directives upon admission to the facility including the resident's rights regarding refusal of treatment. The policy further directed that the advance directives form would be signed and dated by the resident and the person who reviewed the advance directives with the resident. 47457

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #66) reviewed for pressure ulcers, the facility failed ensure the APRN/physician and resident representative were notified, of a newly identified skin blister, in a timely manner.The findings include: Resident #66 was admitted to the facility on [DATE] with diagnoses which included dementia, severe protein-calorie malnutrition, and adult failure to thrive. The annual MDS assessment dated [DATE] identified Resident #66 had severely impaired cognition, was at risk for developing pressure ulcers/injuries, was always incontinent of bowel and bladder, and was dependent on staff for chair/bed-to-chair transfers and rolling left to right. The care plan dated 1/26/24 identified Resident #66 was at risk for alterations in skin integrity related to incontinence of bowel and bladder, severe malnourishment, and failure to thrive. Interventions included to inspect skin for signs and symptoms of breakdown including bruising, rashes and infection when providing care and report any issues, keep skin clean and dry, apply lotions and barrier creams as ordered, and provide wound care and adjust wound care treatments as ordered. The nurse's note dated 2/9/24 at 11:11 PM identified a superficial dime sized area was observed on Resident #66's left hip, the nursing supervisor was notified, and a note was placed in the APRN's book. The nurse's notes dated 2/9/24 through 2/29/24 failed to identify Resident #66's responsible party was notified of the change in skin condition. The nurse's note dated 2/15/24 at 3:40 PM identified Resident #66 was seen by the wound MD; an open blister was noted to the left hip and new orders for bordered hydrogel every 3 days were obtained. The wound specialist progress note dated 2/15/24 identified Resident #66 had a full thickness blister with a status of not healed, wound measurements were 1.0cm x 1.0 cm x 0 cm, a scant amount of sanguineous drainage was noted, and the peri-wound skin texture, moisture and color were normal. Physician's orders directed to apply bordered hydrogel every 3 days and to change as needed for soiling, saturation, or accidental removal. The wound specialist progress note dated 2/29/24 identified the blister to Resident #66's left hip had been resolved. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and clinical record review with the DNS on 3/14/24 at 8:50 AM, indicated that non-emergent matters could be communicated to the medical providers through the APRN communication book and concerns would be addressed on rounds the next day. The DNS further indicated that while the identification of the left hip blister was communicated in the APRN communication binder, it may not have been seen by a medical provider until Monday because the blister was identified on a Friday evening. The DNS identified that because the blister was identified on a Friday, she would have expected a phone call to the on-call provider notifying him/her of the new skin alteration; he/she may want to provide new orders. The DNS further identified that she would expect to see documentation that the resident's representative was notified, as well. Interview with APRN #1 on 3/14/24 at 9:06 AM identified that the APRN communication book can be used for non-emergencies, however she would have expected the facility to notify the on-call physician, in this case. The Change in Resident Condition/Family/MD Notification policy directs when there is a significant change in the condition of a resident's physical, mental, or emotional status the resident's attending physician and responsible party shall be notified, and an RN assessment will be conducted. The Pressure Ulcer Prevention policy directs the notification of the attending physician and family/guardian if a new skin alteration is noted.

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

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 37293

Based on review of the clinical records, review of facility documentation, and interviews for 1 of 5 residents (Resident #31) reviewed for staff to resident abuse, the facility failed to ensure Resident #31 was free from abuse and for 3 of 5 residents (Resident #62, Resident #74 and Resident #76) reviewed for resident to resident abuse, the facility failed to ensure adequate supervision was provided for a resident with intrusive behaviors which resulted in physical abuse. The findings include:

1. Resident #31 was admitted to the facility with diagnoses which included dementia, traumatic brain injury, and dysphasia.

A physician's order dated 12/16/22 directed when out of bed Resident #31 was to sit in an adaptive tilt in space wheelchair with specialty cushion with bilateral elevating leg rests and a head support via standing mechanical lift with assist of 2. Reposition every 2 hours and sit upright for meals.

The annual MDS assessment dated [DATE] identified Resident #31 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance with toileting and eating and required total assistance with personal hygiene, dressing, bed mobility and transfers. Additionally, Resident #31 had no behaviors of physical or verbal directed towards others.

The care plan dated 1/31/23 identified an alleged staff to resident altercation. Interventions included to report incident to family and physician, watch for any signs of distress, and investigate per facility policy.

The reportable event dated 1/31/23 at 12:45 PM alleged LPN #8 forced crushed medications into Resident #31's mouth while holding the resident's left wrist down which resulted in the resident sustaining a cut on the lip. Additionally, LPN #8 allegedly spoke to the resident in Spanish using profanity. The APRN was notified on 1/31/23 at 1:00 PM however the police were not notified.

The time clock punch detail for LPN #8 identified that he clocked in on 1/31/23 at 7:17 AM until 3:15 PM (2.5 hours after incident).

A written statement by RN #4 on 1/31/23 identifed an incident occurred at 12:45 PM where she was notified by the DNS that the charge nurse (LPN #8) was holding residents' arm down and forcefully spooning medication into resident's mouth and he/she was bleeding. This writer assessed resident for injuries in the mouth area and gums. No injury or bleeding observed. Resident #31 was sitting in wheelchair and sleeping.

A written statement by the prior DNS #2 on 1/31/23 at 1:15 PM indicated NA #1 and NA #3 went to her office and reported they witnessed LPN #8 hold down Resident #31's arm and shove medication on a spoon into the resident's mouth. Additionally, they reported the residents' lip was bleeding. NA #1 and #3 reported that LPN #8 whispered to Resident #31 in Spanish using profanity.

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The nurse's note written by RN #4 on 1/31/23 at 3:00 PM indicated this writer was informed by staff members an incident occurred at 12:45 PM they allegedly witnessed charge nurse treating a resident poorly. This writer updated DNS, and investigation was initiated. RN#4 performed a head-to-toe assessment on the resident, no injuries observed. Call made to update APRN with no new orders at this time. A reportable event completed by DNS #2 on 1/31/23 at 3:42 PM indicated she was reporting an alleged staff to resident abuse and she was first aware of incident on 1/31/23 at 1:00 PM. DNS #2 indicated that it was reported that an LPN held a combative resident's left wrist and aggressively administered medications and whispered to Resident #31 in Spanish using profanity. It was reported that resident could have sustained a cut on his/her lip from the encounter. Resident #31 does not recall the incident. APRN aware and LPN sent home until further investigation. A written statement by LPN #8 on 1/31/23 indicated at approximately 1:00 PM NA # 1 informed this nurse that Resident #31 needed medication because he/she was yelling and disruptive to other residents. LPN #8 indicated he went to medicate Resident #31 with his/her 2:00 PM dose of Trazodone and the resident was very combative. LPN #8 indicates he held up his hand against resident because Resident #31 was swinging his/her arms at LPN #8's face level. LPN #8 indicated there was a nursing assistant present that was assisting with the administration of the medication. LPN #8 indicated the nursing assistant told Resident #31 in Spanish who she was, and Resident #31 calmed down and took the medication. LPN #8 felt that he was being targeted by the nursing assistants because he had told one nursing assistant to take his gloves off in the hallway. LPN #8 indicated at no time was he unprofessional to the staff or residents. Interview with LPN #7 on 3/13/24 at 9:30 AM indicated that she remembers that she was sitting at the nurses station and heard Resident #31 talking loud which is Resident #31's baseline and when she stood up and she witnessed LPN #8 talking mean to Resident #31 and being very aggressive trying to place a spoon with medications in Resident #31's mouth. LPN #7 indicated she went over to Resident #31 right away, but LPN #8 was done and had started walking away. LPN #7 indicated that LPN #8 held Resident #31's left arm down forcefully with LPN #8's right hand. LPN #7 indicated that LPN #8 was forcing the medications with his left hand on a spoon. LPN #7 indicated that Resident #31 never cries but on this day Resident #31 was crying during and after the incident. LPN #7 indicated she saw a crack/broken skin on Resident #31's bottom lip, but it was not bleeding. LPN #7 indicated she then reported it to RN #4. LPN #7 indicated that RN #4 did not take the allegation seriously and LPN #8 worked until the end of the shift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with NA#2 on 3/13/24 at 10:37 AM identified she was standing by nurses' station in the community room, and she could see Resident #31 sitting in his/her wheelchair at a table in community room. NA #2 indicated she saw LPN #8 forcefully slam Resident #31's left arm down onto the armrest of the wheelchair and shovel the medicine in Resident #31's mouth while Resident #31 was resisting the medication by turning his/her head side to side. NA #2 indicated that Resident #31 was saying no, no, no and shaking his/her head side to side. NA #2 indicated at no time did Resident #31 raise his/her arms. LPN #8 was very aggressive with Resident #31 by shoving the spoon with medicine in his/her mouth. NA #2 indicated NA #3 was present and spoke Spanish and understood what LPN #8 had said to Resident #31. NA #2 indicated whatever LPN #8 said to Resident #31 at the end really agitated Resident #31. NA #2 indicated that NA #1 was present. NA #2 indicated she saw blood on Resident #31's had blood in his/her mouth from the cut on his/her lower lip from the spoon. NA #2 indicated she became upset when she saw the blood in the residents mouth. NA #2 indicated that Resident #31's hands were shaking on the wheelchair arm rest at the table after incident and Resident #31 was crying like a child in trouble and was asking for his/her mother. NA #2 stated she never had observed Resident cry like that before. NA #2 indicated she reported it immediately to RN #4, but RN #4 really wasn't listening and brushing NA #2 off. NA #2 indicated she later went to the prior Administrator #2 and reported the incident because nothing was getting done. NA #2 indicated that Administrator #2 had her write a statement and she informed the Administrator #2 that there were other people standing there that witnessed the incident. NA #2 indicated that LPN #8 did not get sent home after the incident it wasn't until after she had reported it to Administrator #2 that a short time after that LPN #8 was sent home but it was at the end of the shift. Interview with SW #1 on 3/14/24 at 10:14 AM indicated that she recalled the incident from 1/31/23 and Resident #31 was limited verbally and unable to state what happened. SW #1 indicated that Resident #31's baseline is to shout as his/her normal tone of voice and could say yes and no, simple words, and calls out for his/her mother. SW #1 indicated that Resident #31 could shake his/her head but doesn't have good motor skills. SW #1 indicated that Resident #31 hands and arms shake sometimes. SW #1 indicated there was nursing staff that witnessed the incident, but she did not see the incident occur. SW #1 indicated she had just met with the resident, and he/she did not recall the incident the next day. Review of the facility Abuse Policy identified to ensure each resident is treated with kindness, compassion, and in a dignified manner. Additionally, to ensure any alleged abuse is thoroughly investigated and acted upon in accordance with all regulations and applicable laws. Abuse or mistreatment of any kind towards a resident is strictly prohibited. Allegations of abuse, by any individual towards a resident must be reported immediately to a facility supervisor. Abuse shall be defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Pre-hire screening of licensed staff and reference checks for all potential employees including previous employers. Investigation indicated that anyone who witnesses or has knowledge of abuse or mistreatment must report it immediately to the supervisor, DNS, and Administrator. The DNS or designee shall notify the resident representative, physician, DPH, and local police. The individual accused will be immediately suspended without pay pending the investigation. In conducting the investigation, the Administrator, DNS, or designee will interview all witnesses including the person accused of abuse, interview anyone with knowledge useful to the investigation. Documenting the conclusion of the investigation and actions taken on the internal investigation form. Follow up with the DPH reporting the conclusion and/or action taken and submission to FLIS within 5 days after the alleged incident. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER: Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE: 451 North High Street East Haven, CT 06512	

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility Resident [NAME] of Rights identified residents have the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. Residents have the right to be treated with consideration, respect, and full recognition of their dignity and individuality. 2. Resident #62 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebrovascular disease affecting the left side, diabetes, and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #62 had severely impaired cognition, identified no behaviors, and required total dependence for transfers with a mechanical lift with assistance of 2, and utilized a wheelchair for mobility. The November 2023 care plan identified Resident #62 was on psychotropic medications. Interventions included to administer medications as ordered, and adjust medication as needed. Offer support and reassurance if anxious. Review of the reportable event form dated 12/29/23 at 1:50 PM identified a resident to resident abuse without injury. Resident #62 attempted to redirect Resident #74 by self-propelling his/her wheelchair into Resident #74 to prompt Resident #74 to leave the room. Resident #62 made contact with Resident #74 lower extremities with his/her wheelchair. Resident #74 bent down to touch his/her leg and Resident #62 struck Resident #74 on the back. Resident #74 stood up and struck Resident #62 in the face. No injuries were noted. Both residents were immediately separated and Resident #74 was placed on 1:1 monitoring. A stop sign was placed across Resident #62's room door following the incident. A statement by RN #9 (Regional Clinician) dated 12/29/23 identified a resident to resident altercation reported by LPN #7. Resident #74 is eyes on supervision due to wandering and aggression. The staff reported Resident #74 has exhibited increase anxiousness due to not seeing his/her daughter in a few days. Resident #74 went into Resident #62's room and NA#9 witnessed Resident #62 running his/her wheelchair into Resident #74 leg. Resident #74 bent down to touch his/her leg and Resident #62 hit him/her on the back. As Resident #74 was standing up he/she struck Resident #62 in the face. RN #9 indicated Resident #62 has a small scratch on the inner right eye lid and Resident #74 was noted to be limping. 3. Resident #74 was admitted to the facility on [DATE] with diagnoses which included vascular dementia with behavioral disturbance, vascular dementia with mood disturbance, psychotic disturbance, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #74 had severely impaired cognition, exhibited wandering behavior, and was independent with bed mobility and transfer. The care plan dated 10/23/23 identified Resident #74 tends to wander around the unit looking for his/her sister, granddaughter, daughter, and keys at times. Interventions included to offer emotional support as needed. The care plan dated 10/23/23 identified Resident #74 was at risk for an alteration in mood and behaviors as evidence by wandering in and out of rooms at times. Interventions included one on one for mood/behaviors as ordered, psychiatric followed up as ordered and wanderguard bracelet. (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The nurse's note dated 12/1/23 - 12/28/23 failed to reflect consistent and complete documentation of Resident #74 behaviors. The nurse's note dated 12/29/23 at 6:58 AM identified Resident #74 was alert and confused. Resident #74 complained of pain in the left leg Resident #74 was restless during the shift, wandering into many resident rooms and had to be redirected multiple times. Review of clinical record for the month of December 2023 failed to reflect consistent documentation of Resident #74 behavior monitoring with the use of Trazodone medication for dementia behavior, sundowning, decreased sleep, increased yelling, and wandering at hours of sleep. The nurse's note dated 12/29/23 at 2:06 PM identified Resident #74 was observed urinating and defecating on the floor on the unit. Resident #74 was wandering on the unit and was noted walking into Resident #62's room. An altercation transpired between the two residents and Resident #74 punched Resident #62 in the face. The supervisor, APRN, and the resident representative were notified. Resident #74 was placed on on one to one for the remainder of the shift. A statement by NA #9 dated 12/29/23 identified Resident #74 had refused care today. Resident #74 was very restless and he/she has been up all night. Resident #74 has been going into other resident rooms and going through their belongings and many residents were yelling at Resident #74. NA #9 indicated she saw Resident #74 going into Resident #62's room. NA #9 indicated she saw Resident #62 propelled his/her wheelchair into Resident #74's leg when he/she was entering his/her room. NA #9 indicated Resident #74 bent over to touch his/her leg and Resident #62 hit him/her on the back. NA #9 indicated Resident #74 then struck Resident #62 in the face. A statement by RN #9 (Regional Clinician) dated 12/29/23 identified a resident to resident altercation was reported by LPN #7. Resident #74 is on eyes on supervision due to wandering and aggression. The staff reported that Resident #74 has exhibited increase anxiousness due to not seeing his/her daughter in a few days. Resident #74 normally wanders. Resident #74 went into Resident #62's room. It was witnessed by NA #9 Resident #62 ran his/her wheelchair into Resident #74 leg, and Resident #74 bent down to touch his/her leg and Resident #62 hit his/her on the back. As Resident #74 was standing up he/she struck Resident #62 in the face. RN #9 indicated Resident #62 has a small scratch on the inner right eye lid. Resident #74 was noted to be limping, resident was seen by the physician assistant with orders to obtained an X-ray of the left ankle. The psych APRN note dated 12/29/23 identified Resident #74 had an altercation with another resident. Resident #74 was alert and oriented. Resident #74 doesn't remember the incident and stated he/she would not hurt anyone. Resident #74 is not considered a danger to self or others. Discontinue one to one. Trazodone 25 mg every 8 hours as needed for 14 days for anxiety.(Trazadone is an antidepressant medication that may take two weeks for symptoms to improve) The revised care plan dated 12/29/23 identified Resident #74 was at risk for an alteration in mood and behaviors as evidence by wandering in and out of rooms at times. On 12/29/23 Resident #74 wandered into another resident's room. Interventions included adjusting medications as ordered. X-ray as ordered. Redirect when entering another resident's room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A physician's order dated 1/1/24 directed to administer Trazodone HCl (antidepressant medication) 50 mg in the afternoon for dementia behavior and sundowning. Trazodone HCl 100 mg at bedtime for decreased sleep, increased yelling, wandering at hours of sleep. Trazodone HCl 25 mg every 8 hours as needed for anxiety for 14 days. Review of the MAR dated 1/1/24 - 1/10/24 identified Trazodone HCl 25 mg every 8 hours as needed for anxiety for 14 days. The documentation identified the medication was only administered once between 1/1/24 - 1/10/24. Resident #74 received the medication on 1/2/24 at 6:50 PM with effect. Review of clinical record for 1/1/24 - 1/10/24 failed to reflect consistent documentation of Resident #74 behavior monitoring with the use of Trazodone medication for dementia behavior, sundowning, decreased sleep, increased yelling, wandering at hours of sleep, and anxiety. Review of the summary report dated 1/4/24 at 3:13 PM identified both residents experience cognitive impairment. Resident #62 was aphasic and not able to respond verbally to questions and has a history of being aggressive toward others. Resident #74 has a baseline tendency to wander. On 12/29/23 the day of the altercation Resident #74 was upset that his/her daughter had not visited in 2 days and was up late the evening before (12/28/23), and early the day of and was wandering into resident rooms more than normal. When Resident #74 entered Resident #62's room that day, Resident #62 responded by hitting him/her with the wheelchair and in response Resident #74 punched Resident #62 in the face. Neither resident sustained any injuries. Resident #62 was placed at the nurse's station for direct observation and Resident #74 was placed on 1:1 monitoring pending evaluation of both resident by psychiatry. Both residents were evaluated by psychiatry and determined not to be a risk of injury to self or others. Interventions were put into place for both residents to prevent further altercations. A stop sign was placed on the door of Resident #62's room as a deterrent for Resident #74 to keep out of his/her room. Resident #74 will be redirected by staff when he/she wanders to prevent him/her from entering Resident #62's room. The 1:1 observation was discontinued once both residents were cleared by psychiatry. The summary report failed to reflect documentation of Resident #62 had sustained a scratch below the right eyebrow. Review of the facility abuse/resident policy identified to ensure each resident is treated with kindness, compassion and in a dignified manner. To ensure any alleged abuse is thoroughly investigated and acted upon in accordance with all regulations and applicable laws. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. 4. Resident #76 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, anxiety disorder, and osteoarthritis. The quarterly MDS assessment dated [DATE] identified Resident #76 moderately impaired cognition, identified no behaviors, and required substantial/maximal assistance with personal hygiene. A physician's order dated 1/1/24 directed to administer Paroxetine HCl (antidepressant) 20 mg one time a day related to anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The nurse's note dated 1/10/24 at 5:26 AM by RN #8 (1/9/24 on 11:00 PM - 7:00 AM nursing supervisor) identified she was notified by the license nurse that Resident #76 was involved in an incident with another resident. RN #8 spoke with Resident #76 who stated that he/she was sound asleep and was startled awake by Resident #74 standing over him/her looking for something. Resident #76 indicated he/she waved his/her hands telling Resident #74 to go back to his/her room, but the resident was insisting Resident #76 had the keys. Resident #76 indicated Resident #74 was swinging his/her arms and hit Resident #76 on the hand and hip (pointing to right hip). Resident #76 had no complaint of pain, no bruising, abrasions, or skin tear noted. Vital signs 97.9 - 65 - 19 - 122/60 - 93% on room air. The police were notified and interviewed Resident #76. The DNS was notified and will contact the Administrator. The APRN was notified. Message left for psych APRN. Resident representative was updated on overnight incident. A statement by NA #7 dated 1/10/24 identified she noticed Resident #76 saying something in a loud voice. NA #7 indicated when she arrived at Resident #76 room, she saw Resident #74 was in the room speaking in a loud angry voice to Resident #76 to give him/her the keys. Resident #76 stated she did not have the keys and Resident #74 was to go back into his/her room. NA #7 indicated she was redirecting Resident #74 out of the room and explaining to him/her that it was 3:00 AM and Resident #76 was trying to go to sleep. NA #7 indicated Resident #74 was very agitated and not happy. NA #7 indicated Resident #74 pushed Resident #76 hands and telling him/her to give the keys. NA #7 indicated she got in between the residents and spoke to Resident #74 and redirect him/her back to his/her room. NA #7 indicated she made sure Resident #74 was calm and then she notified the nurse. The APRN note dated 1/10/24 at 12:23 PM identified Resident #76 was seen after being involved with another resident, Resident #76 was hit on hand and hip. Skin is clear and intact, denies any pain. Resident #76 claimed he/she understands his/her aggressor and is not upset about it, alert and oriented. The social service note dated 1/10/24 at 2:14 PM identified follow up regarding altercation. Resident #76 alert and oriented, able to recall details of the event. Resident #76 is very compassionate, verbalized understanding resident who entered the room has impairment it just disrupted his/her sleep. Resident #76 expressed he/she feels very safe at the facility and is empathetic to the situation with no further concerns. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the summary report by the DNS dated 1/14/24 at 1:26 PM identified on 1/10/24 Resident #74 wandered and startled Resident #76 who was sleeping in his/her room. On this occasion Resident #74 was having delusions that he/she was looking for his/her keys and believed that Resident #76 had them despite Resident #76 stating a number of times that he/she did not have the keys. Resident #74 then struck Resident #76. Resident #76 stated it felt more like a love tap and no injuries occurred to both residents. Resident #74 is experiencing delusions that are new and required psych evaluation of these behaviors and review of current medications. Upon completion of this investigation medications were adjusted and a new medication for delusions and agitation was added. Resident #74 was placed on 1:1 observation. Resident #74 was seen by the psych APRN and was deemed not to be a risk of injury to self or others and the 1:1 observation was discontinued. Resident #74 was placed on every one hour behavioral observations were implemented requiring staff to document what he/she was doing and interventions that were implemented. On 1/11/24 Resident #74 medications were adjusted Trazodone dosing was changed, and Seroquel was added to address the delusions and agitation. During the 48-hours observation period Resident #74 was noted to be either sitting in his/her room, sleeping or in the common room socializing and eating with other residents. Resident #74 behaviors were currently being observed every hour for the next 48-hours to assure the medications started are working to address the behaviors. Interview with the DNS on 3/14/24 at 10:35AM indicated Resident #74 was placed on 1:1 monitor with every resident to resident altercation. The DNS indicated Resident #74 was evaluated by the psych APRN who discontinued the 1:1 monitoring after each evaluation, reviewed and adjusted the medications, and the care plans have been revised. The DNS indicated with the 1/10/24 resident to resident altercation the psych APRN has added a new antipsychotic medication. The DNS failed to provide evidence that additional supervision was provided and/or additional interventions were implemented for Resident #74 following the discontinuation of 1:1 monitoring while the effectiveness of the new medication was being evaluated beyond a 48 hour time period. Review of the facility Abuse/Resident policy identified to ensure each resident is treated with kindness, compassion and in a dignified manner. To ensure any alleged abuse is thoroughly investigated and acted upon in accordance with all regulations and applicable laws. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, review of facility documentation, and interviews for one resident (Resident #20) reviewed for misappropriation of resident property, the facility failed to ensure the resident was free from misappropriation of an ordered (Scheduled II Controlled Drug) medication. The findings include: Resident #20 was admitted to the facility in December 2022 with diagnoses which included Alzheimer's disease, vascular dementia with behavioral disturbance, and vascular dementia with agitation. Review of the Controlled Substance Disposition Record (CSDR) dated 5/19/23 for Morphine Sulfate 100 mg/5 ml Solution take 0.25 ml (5 mg total) by mouth every 3 hours as needed for moderate pain or severe pain and shortness of breath. Maximum daily amount of 40 mg. Review of the Controlled Substance Disposition Record (CSDR) dated 5/19/23 for Morphine Sulfate 100 mg/5 ml Solution for Resident #20. Identified on 12/3/23 at 9:15 AM 0.25 ml was borrowed for another resident with 2 licensed staff signatures on the CSDR. On 12/3/23 at 9:30 AM 0.50 ml was borrowed for another resident with 2 licensed staff signatures on the CSDR. On 12/3/23 at 10:00 AM 0.5 ml was borrowed for another resident with 2 licensed staff signatures on the CSDR. The quarterly MDS assessment dated [DATE] identified Resident #20 was severely cognitively impaired and required total dependence with personal hygiene. Resident #20 was identified receiving scheduled pain medication regimen. Physician's order dated 12/1/23 directed to administer Morphine Sulfate Oral Solution 20 mg/ml (Schedule II Controlled Drug) give 0.25 ml sublingually every 3 hours as needed for pain or shortness of breath. The care plan dated 3/8/24 identified Resident #20 may take opioid medications to help manage moderate to severe pain and was receiving Hospice services. Interventions included to administer medications as ordered by the physician. Determine level of pain using scale (verbal or nonverbal) before administering as needed medications. Interview with the Administrator on 3/11/24 at 3:28 PM identified she was not aware of controlled substances medication was borrowed from Resident #20 for other another resident. The Administrator indicated the licensed nurses are aware that they are not supposed to borrow controlled substance medications. The Administrator indicated the licensed nurses are to notify the supervisor when controlled substance medications are unavailable and to notify the pharmacy. Interview with RN #1 on 3/12/24 at 10:32 AM identified she has been employed by the facility since October 2023. RN #1 indicated she was not aware that she cannot borrow narcotics or controlled substance medications from Resident #20 to administer to another resident. RN #1 indicated this is her first long term care position in the nursing home. RN #1 indicated in the beginning of 2024 was when she found out that she was not supposed to borrow controlled substance medication from Resident #20 to give to another resident. RN #1 indicated she does not remember which residents the controlled substance was borrowed for. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the DNS on 3/12/24 at 10:46 AM identified she was not aware of the issue until yesterday (3/11/24). The DNS indicated there is no borrowing of narcotics and controlled substances. The DNS indicated RN #1 should have checked the Omnicell and/or called the pharmacy. The DNS indicated RN #1 should have called the physician/APRN for another controlled substance for the resident that the controlled substance was borrowed for. Interview with MD #1 (Medical Director) on 3/13/24 at 11:10 AM identified he was not aware of the issue. MD #1 indicated the license nurses should not have borrowed controlled substance medications from one resident for another resident. MD #1 indicated the license nurse should have called the physician/APRN for another controlled substance medication. Review of the facility abuse/resident policy identified to ensure each resident is treated with kindness, compassion and in a dignified manner. To ensure any alleged abuse is thoroughly investigated and acted upon in accordance with all regulations and applicable laws. Abuse or mistreatment of any kind toward a resident is strictly prohibited. Allegations of abuse by any individual (staff, family, visitor, resident) toward a resident must be reported immediately to a facility supervisor. All allegations will be thoroughly investigated and acted upon according to the steps of this policy. Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the residents consent. Review of the Verification: Access to and administration of controlled substances form identified to document nursing confirmation that she/he will adhere to all required processes in place to assure that controlled substances are handled safely. It is mandatory for all Registered Nurse's (RN'S) and Licensed Practical Nurses (LPN'S) to sign who have access to and administer any controlled substances while employed at facility. I will not borrow any controlled substance from one resident and administer it to another resident. If ordered controlled substance for a resident has not been received from the pharmacy I will attempt to obtain it from the Omnicell. If it is not available in the Omnicell I will notify the provider for further orders. I will never sign out a controlled substance and give it to another nurse to administer to a resident.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of facility documentation, facility policy, and interviews for 6 of 7 personnel files reviewed, the facility failed to conduct required background checks for newly hired licensed nurses and certified nurse aides prior to hire. The findings include: Review of NA #2's personnel file identified that she was hired on 9/1/21 and failed to contain documentation that the required background checks were completed. Review of NA #4's personnel file identified that she was hired on 9/2/22 and failed to contain documentation that the required background checks were completed. Review of RN #7's personnel file identified that she was hired on 7/18/20 and failed to contain documentation that the required background checks were completed. Review of LPN #10's personnel file identified that she was hired on 3/29/23 and failed to contain documentation that the required background checks were completed, including fingerprinting.1. Employee File for LPN #8 identified he started working for the facility on 12/27/22 and was terminated on 2/20/23 with the last day worked on 2/15/23. Termination report indicated LPN #8 was not eligible for rehire and was not eligible to be paid his PTO time. On LPN #8's Job Application indicated he currently was not employed. Last place of employment at a nursing facility, RN #4 was his supervisor. Additionally, it asked Have you ever been convicted of a crime of any of the following: a felony, cruelty to persons under CGS 53-20, assault of a victim [AGE] years or older under CGS 53a-61 or has been subject to any decision imposing disciplinary action by the licensing agency in any state or foreign jurisdiction? LPN #8 did not answer yes or no. The verification of the nursing license was on 3/7/23 (There were no disciplinary/council forms in the file after 2 allegations of abuse one on 1/31/23 and one dated 2/15/23. File did not reflect reference checks, license verification at hire, nor the background checks. Employee File for RN #4 identified on the Job Application that she was referred to facility by a personal reference LPN #8. LPN #8 and RN #4 had the same address. RN #4 indicated she had not been convicted of a crime. RN #4 started working for the facility on 1/8/23 and she resigned effective immediately on 7/17/23. RN #4 file did not reflect verification of a nursing license, no references, and no background check (ABCMS). RN #4 had disciplinary action dated 5/9/23 due to RN#4 refused to come into facility for shift while on call RN #4 was given a written warning and if occurs again will be suspension and placed on 90-day probation. RN #4 had disciplinary action dated 5/26/23 for tardiness and call outs given a 90-day probation and if behavior continues will be suspension/termination. (continued on next page)

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 03/14/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with Human Resources Coordinator (HR) on 3/13/24 at 11:20 AM indicated he had started at the facility about 3 months ago. HR indicated he had reviewed the employee files for RN #4 and LPN #8, and he did not find the background checks (ABCMS), research services background check, or the 2 references needed identifying that RN #4 and LPN #8 were eligible for hire. HR indicated that an employee cannot start orientation until the ABCMS comes back and states the employee was eligible for hire. HR indicated that if a potential employee already had already their fingerprints on file with ABCMS (good for 3 years) the facility would accept it and print it and place in the employees file but would additionally do another background check from research services prior to the potential employee starting. HR #1 indicated that there were not 2 reference checks, ABCMS, or research services background checks in RN #4 or LPN #8's employee files. HR indicated neither should have started working without those items being completed first. Interview with the HR Coordinator on 3/14/24 at 11:35 AM identified that he began his employment at the facility on 12/28/23 and that the employee personnel files reviewed during survey had their pre-hire screenings completed prior to his employment with the facility. The HR Coordinator indicated that he was not able to identify documentation for NA #2, NA #4, RN #7, and LPN #10's background checks in their personnel file or in the facility's shared drive that houses new hire's application documents. The HR Coordinator further indicated that he was also unable to identify that LPN #10's fingerprinting was completed through ABCMS or in the facility's shared drive. The HR Coordinator identified that in accordance with the facility's pre-hire checklist the following documentation should be on file prior to a new employee beginning employment: copy of license/certification, CT and National sex offender registry, exclusion screening verification, ABCMS background check, third party background check, and reference checks. The HR Coordinator indicated that he has already started the process of auditing employee files to ensure the pre-hire background checks were completed and the employee's personnel file reflects the appropriate documentation; moving forward he will continue to work with the Administrator to ensure best practice and that audits of all employee personnel will be completed for the required pre-hire screenings and documentation. Interview with the Administrator on 3/14/24 at 11:47 AM identified that she began her employment at the facility on 10/16/23 and that her expectation would be that all pre-hiring screening, including the required background checks, would be completed in accordance with the facility's pre-hire checklist. The Facility Pre-hire Checklist Form identified the facility needed the following: copy of license or certification, Connecticut and National sex offender registry, exclusion screening verification, ABCMS background check and date sent, research services background check and date sent, copy of covid vaccination card, check 2 references, and offer letter. The Employee Handbook identified there was a pre-employment post offer the final acceptance to the position will be contingent upon the outcome of the criminal background checks and drug screen. Conflict of interest all employees have an obligation to conduct business within guidelines that prohibit actual or potential conflicts of interest. In order to avoid any favoritism or to prevent an employee from having an improper advantage or gain, an employee should inform the facility if he/she has a personal relationship, or any member of employee's family or household or a person whom the employee has a personal relationship, or provides services.

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 03/14/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #31) reviewed for abuse, the facility failed to ensure the local law enforcement was notified of a staff to resident abuse per facility policy. The finding include: Resident #31 was admitted to the facility with diagnoses which included dementia, tramatic brain injury, and dysphasia. A physician's order dated 12/16/22 directed when out of bed Resident #31 was to sit in an adaptive tilt in space wheelchair with specialty cushion with bilateral elevating leg rests and a head support via standing mechanical lift with assist of 2. Reposition every 2 hours and sit upright for meals. The annual MDS assessment dated [DATE] identified Resident #31had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance with toileting and eating and required total assistance with personal hygiene, dressing, bed mobility and transfers. Additionally, Resident #31 had no behaviors of physical or verbal directed towards others. The care plan dated 1/31/23 identified an alleged staff to resident altercation. Interventions included to report incident to family and physician, watch for any signs of distress, and investigate per facility policy. The reportable event dated 1/31/23 at 12:45 PM alleged LPN #8 forced crushed medications into Resident #31's mouth while holding resident left wrist down which resulted in the resident sustaining a cut on the lip . Additionally, LPN #8 allegedly spoke to the resident in Spanish using profanity. The APRN was notified on 1/31/23 at 1:00 PM however the police were not notified. The timeclock punch detail for LPN #8 identified that he clocked in on 1/31/23 at 7:17 AM until 3:15 PM (2.5 hours after incident). A written statement by RN #4 on 1/31/23 identified an incident occurred at 12:45 PM where she was notified by the DNS that the charge nurse (LPN #8) was holding residents' arm down and forcefully spooning medication into resident's mouth and he/she was bleeding. This writer assessed resident for injuries in the mouth area and gums. No injury or bleeding observed. Resident #31 was sitting in wheelchair and sleeping. A written statement by the prior DNS #2 on 1/31/23 at 1:15 PM indicated NA #1 and NA #3 went to her office and reported they witnessed LPN #8 hold down Resident #31's arm and shove medication on a spoon into the resident's mouth. Additionally, they reported the residents' lip was bleeding. NA #1 and #3 reported that LPN #8 whispered to Resident #31 in Spanish using profanity. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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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 Note: The nursing home is disputing this citation.	The nurse's note written by RN #4 on 1/31/23 at 3:00 PM indicated this writer was informed by staff members an incident occurred at 12:45 PM they allegedly witnessed charge nurse treating a resident poorly. This writer updated DNS, and investigation was initiated. RN#4 performed a head-to-toe assessment on resident, no injuries observed. Call made to update APRN with no new orders at this time. Attempted to update resident representative left a message. Reportable event to FLIS written by prior DNS #2 on 1/31/23 at 3:42 PM indicated she was reporting alleged staff to resident abuse and she was first aware of incident on 1/31/23 at 1:00 PM. DNS #2 indicated that it was reported that an LPN held a combative resident's left wrist and aggressively administered medications and whispered to Resident #31 in Spanish using profanity. Reported that resident could have sustained a cut on his/her lip from the encounter. Incident occurred in the common area. Resident #31 does not recall the incident. APRN aware and LPN sent home until further investigation. Resident #31 was a hoyer (mechanical lift) with the assistance of 2 and required total assistance with activities of daily living. NA #3 was a witness. Law Enforcement agency was not notified. Interview with LPN #7 on 3/13/24 at 9:30 AM indicated that she remembers that she was sitting at the nurses station and heard Resident #31 talking loud which is Resident #31's baseline and when she stood up and she witnessed LPN #8 talking mean to Resident #31 and being very aggressive trying to place spoon with medications in Resident #31's mouth. LPN #7 indicated she went over to Resident #31 right away, but LPN #8 was done and had started walking away. LPN #7 indicated that LPN #8 held Resident #31's left arm down forcefully with LPN #8's right hand. LPN #7 indicated that LPN #8 was forcing the medications with his left hand on a spoon. LPN #7 indicated that Resident #31 never cries but on this day Resident #31 was crying during and after the incident. LPN #7 indicated she saw a crack/broken skin on Resident #31's bottom lip, but it was not bleeding. LPN #7 indicated she then reported it to RN #4. LPN #8 was very aggressive. LPN #7 indicated that Resident #31 always talks loud but never cries and on this day was crying. LPN #7 indicated that RN #4 did not take the alllegation seriously and LPN #8 worked until the end of the shift. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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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 Note: The nursing home is disputing this citation.	Interview with NA#2 on 3/13/24 at 10:37 AM identified she was standing by nurses' station in the community room, and she could see Resident #31 sitting in his/her wheelchair at table in community room. NA #2 indicated she saw LPN #8 forcefully slam Resident #31's left arm down onto the armrest of the wheelchair and shovel the medicine in Resident #31's mouth while Resident #31 was resisting the medication by turning his/her head side to side. NA #2 indicated that Resident #31 was saying no, no, no and shaking his/her head side to side. NA #2 indicated at no time did Resident #31 raise his/her arms. LPN #8 was very aggressive with Resident #31 by shoving the spoon with medicine in his/her mouth. NA #2 indicated NA #3 was present and spoke Spanish and understood what LPN #8 had said to Resident #31. NA #2 indicated whatever LPN #8 said to Resident #31 at the end really agitated Resident #31. NA #2 indicated that NA #1 was present. NA #2 indicated she saw blood on Resident #31's had blood in his/her mouth from the cut on his/her lower lip from the spoon. NA #2 indicated she became upset when she saw the blood in the residents mouth.NA #2 indicated that Resident #31's hands were shaking on the wheelchair arm rest at the table after incident and Resident #31 was crying like a child in trouble and was asking for his/her mother. NA #2 stated she never had seen Resident cry like that before. NA #2 indicated she reported it immediately to RN #4, but RN #4 really wasn't listening and brushing NA #2 off. NA #2 indicated that when the staff reported it to RN #4, she wasn't taking the staff seriously. NA #2 indicated so she later went to the prior Administrator #2 and reported the incident because nothing was getting done. NA #2 indicated that Administrator #2 had her write a statement and she informed the Administrator #2 that there were other people standing there that witnessed the incident. NA #2 indicated that LPN #8 did not get sent home after the incident it wasn't until after she had reported it to Administrator #2 that a short time after that LPN #8 was sent home but it was at the end of the shift. Although attempted, an interview with prior Administrator #2, prior DNS #2, RN #4, LPN #8 were not obtained. Review of the clinical record, interviews and time clock punch detail identified LPN #8 continued to work and placed residents at risk for 2.5 hours after the alleged allegation of abuse. Although attempted, an interview with prior Administrator #2, prior DNS #2, RN #4, LPN #8 were not obtained. Review of the facility Abuse Policy identified to ensure each resident is treated with kindness, compassion, and in a dignified manner. Additionally, to ensure any alleged abuse is thoroughly investigated and acted upon in accordance with all regulations and applicable laws. Abuse or mistreatment of any kind towards a resident is strictly prohibited. Allegations of abuse, by any individual towards a resident must be reported immediately to a facility supervisor. The DNS or designee shall notify the resident representative, physician, DPH, and local police.

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	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Laurel Woods	451 North High Street East Haven, CT 06512

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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 Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #31) reviewed for abuse, the facility failed to ensure residents were protected from potential mistreatment following an allegation of abuse. The findings include: Resident #31 was admitted to the facility with diagnoses which included dementia, tramatic brain injury, and dysphasia. A physician's order dated 12/16/22 directed when out of bed Resident #31 was to sit in an adaptive tilt in space wheelchair with specialty cushion with bilateral elevating leg rests and a head support via standing mechanical lift with assist of 2. Reposition every 2 hours and sit upright for meals. The annual MDS assessment dated [DATE] identified Resident #31had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance with toileting and eating and required total assistance with personal hygiene, dressing, bed mobility and transfers. Additionally, Resident #31 had no behaviors of physical or verbal directed towards others. The care plan dated 1/31/23 identified an alleged staff to resident altercation. Interventions included to report incident to family and physician, watch for any signs of distress, and investigate per facility policy. The reportable event dated 1/31/23 at 12:45 PM alleged LPN #8 forced crushed medications into Resident #31's mouth while holding resident left wrist down which resulted in the resident sustaining a cut on the lip . Additionally, LPN #8 allegedly spoke to the resident in Spanish using profanity. The APRN was notified on 1/31/23 at 1:00 PM however the police were not notified. The time clock punch detail for LPN #8 identified that he clocked in on 1/31/23 at 7:17 AM until 3:15 PM (2.5 hours after incident). A written statement by RN #4 on 1/31/23 identfied an incident occurred at 12:45 PM where she was notified by the DNS that the charge nurse (LPN #8) was holding residents' arm down and forcefully spooning medication into resident's mouth and he/she was bleeding. This writer assessed resident for injuries in the mouth area and gums. No injury or bleeding observed. Resident #31 was sitting in wheelchair and sleeping. A written statement by the prior DNS #2 on 1/31/23 at 1:15 PM indicated NA #1 and NA #3 went to her office and reported they witnessed LPN #8 hold down Resident #31's arm and shove medication on a spoon into the resident's mouth. Additionally, they reported the residents' lip was bleeding. NA #1 and #3 reported that LPN #8 whispered to Resident #31 in Spanish using profanity. (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 Note: The nursing home is disputing this citation.	The nurse's note written by RN #4 on 1/31/23 at 3:00 PM indicated this writer was informed by staff members an incident occurred at 12:45 PM they allegedly witnessed charge nurse treating a resident poorly. This writer updated DNS, and investigation was initiated. RN#4 performed a head-to-toe assessment on resident, no injuries observed. Call made to update APRN with no new orders at this time. Attempted to update resident representative left a message. Reportable event to FLIS written by prior DNS #2 on 1/31/23 at 3:42 PM indicated she was reporting alleged staff to resident abuse and she was first aware of incident on 1/31/23 at 1:00 PM. DNS #2 indicated that it was reported that an LPN held a combative resident's left wrist and aggressively administered medications and whispered to Resident #31 in Spanish using profanity. Reported that resident could have sustained a cut on his/her lip from the encounter. Incident occurred in the common area. Resident #31 does not recall the incident. APRN aware and LPN sent home until further investigation. Resident #31 was a hoyer (mechanical lift) with the assistance of 2 and required total assistance with activities of daily living. NA #3 was a witness. Law Enforcement agency was not notified. Interview with LPN #7 on 3/13/24 at 9:30 AM indicated that she remembers that she was sitting at the nurses station and heard Resident #31 talking loud which is Resident #31's baseline and when she stood up and she witnessed LPN #8 talking mean to Resident #31 and being very aggressive trying to place spoon with medications in Resident #31's mouth. LPN #7 indicated she went over to Resident #31 right away, but LPN #8 was done and had started walking away. LPN #7 indicated that LPN #8 held Resident #31's left arm down forcefully with LPN #8's right hand. LPN #7 indicated that LPN #8 was forcing the medications with his left hand on a spoon. LPN #7 indicated that Resident #31 never cries but on this day Resident #31 was crying during and after the incident. LPN #7 indicated she saw a crack/broken skin on Resident #31's bottom lip, but it was not bleeding. LPN #7 indicated she then reported it to RN #4. LPN #8 was very aggressive. LPN #7 indicated that Resident #31 always talks loud but never cries and on this day was crying. LPN #7 indicated that RN #4 did not take the alllegation seriously and LPN #8 worked until the end of the shift. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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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 Note: The nursing home is disputing this citation.	Interview with NA#2 on 3/13/24 at 10:37 AM identified she was standing by nurses' station in the community room, and she could see Resident #31 sitting in his/her wheelchair at table in community room. NA #2 indicated she saw LPN #8 forcefully slam Resident #31's left arm down onto the armrest of the wheelchair and shovel the medicine in Resident #31's mouth while Resident #31 was resisting the medication by turning his/her head side to side. NA #2 indicated that Resident #31 was saying no, no, no and shaking his/her head side to side. NA #2 indicated at no time did Resident #31 raise his/her arms. LPN #8 was very aggressive with Resident #31 by shoving the spoon with medicine in his/her mouth. NA #2 indicated NA #3 was present and spoke Spanish and understood what LPN #8 had said to Resident #31. NA #2 indicated whatever LPN #8 said to Resident #31 at the end really agitated Resident #31. NA #2 indicated that NA #1 was present. NA #2 indicated she saw blood on Resident #31's had blood in his/her mouth from the cut on his/her lower lip from the spoon. NA #2 indicated she became upset when she saw the blood in the residents mouth.NA #2 indicated that Resident #31's hands were shaking on the wheelchair arm rest at the table after incident and Resident #31 was crying like a child in trouble and was asking for his/her mother. NA #2 stated she never had seen Resident cry like that before. NA #2 indicated she reported it immediately to RN #4, but RN #4 really wasn't listening and brushing NA #2 off. NA #2 indicated that when the staff reported it to RN #4, she wasn't taking the staff seriously. NA #2 indicated so she later went to the prior Administrator #2 and reported the incident because nothing was getting done. NA #2 indicated that Administrator #2 had her write a statement and she informed the Administrator #2 that there were other people standing there that witnessed the incident. NA #2 indicated that LPN #8 did not get sent home after the incident it wasn't until after she had reported it to Administrator #2 that a short time after that LPN #8 was sent home but it was at the end of the shift. Although attempted, an interview with prior Administrator #2, prior DNS #2, RN #4, LPN #8 were not obtained. Review of the clinical record, interviews and punch detail LPN #8 continued to work and placed residents at risk for 2.5 hours after the alleged allegation of abuse. Review of the facility Abuse Policy identified to ensure each resident is treated with kindness, compassion, and in a dignified manner. Additionally, to ensure any alleged abuse is thoroughly investigated and acted upon in accordance with all regulations and applicable laws. Abuse or mistreatment of any kind towards a resident is strictly prohibited. Allegations of abuse, by any individual towards a resident must be reported immediately to a facility supervisor. Investigation indicated that anyone who witnesses or has knowledge of abuse or mistreatment must report it immediately to the supervisor, DNS, and Administrator. The DNS or designee shall notify the resident representative, physician, DPH, and local police. The individual accused will be immediately suspended without pay pending the investigation.

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 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Laurel Woods	451 North High Street East Haven, CT 06512

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 3 residents (Resident #10, #16 and #31) reviewed for care planning, the facility failed to have a comprehensive social worker assessment admission, quarterly, and annual completed timely. The findings include: 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, anxiety, major depression, and paranoid schizophrenia. Review of the clinical record dated 3/17/22 - 3/14/24 identified 1 social services assessment completed on 1/29/24. The Admission assessment dated [DATE] at 1:48 PM identified Resident #10 was transferred from another facility on 3/17/22 at 2:30 PM for long term care. Admission assessment did not reflect a social services assessment was completed. The care plan dated 4/3/22 identified Resident #10 was admitted for long term care. Interventions included to provide social services to provide opportunities to express concerns as needed. Review of the Social Services Assessments were not completed for the admitted d 3/17/22, Quarterly dated 6/2/22, 9/2/22, 11/15/22, 1/20/23, 6/3/23, Annual dated 3/3/23 and Significant Change in Condition assessment dated [DATE]. Interview and clinical record review with SW #1 on 3/14/24 at 9:30 AM identified the Social Worker was responsible to do an admission assessment within one week of admission, a quarterly every 3 months, an annual, and if there is a change in condition MDS. SW #1 indicated there were 2 full time social workers and they just communicate with each other what must get done it is not divided by units or any other system. SW #1 indicated that SW #2 had been there longer and there were families that preferred her. SW #1 indicated additionally the social worker was responsible to complete the MDS sections C, D, E, and Q and just review section B. SW #1 indicated that herself and SW #2 were behind in the assessments, and they open them when a resident has a care plan meeting scheduled but do not have time to complete them until later. SW #1 indicated the quarterly and annual social worker assessments were not completed from 3/17/22 admission until 4/3/23 because there was only 1 social worker at that time out on maternity leave for an extended period. SW #1 indicated that for Resident #10 she had opened the social worker progress note on 9/12/22 and on 4/3/23 but did not complete it until 7/11/23 and that it was not an assessment just a progress note. SW #1 indicated she maybe had paper notes and just had imputed into the computer late. SW#1 indicated that she just did not have time to input notes into her computer due to the workload, that's why the notes were late. SW #1 indicated there were no social worker assessments on admission, quarterly, or annual completed from 3/17/22 - 4/3/23, a quarterly on 6/5/23 or a significant change on 10/30/23. 2. Resident #16 was admitted to the facility on [DATE] with diagnoses which included Alzheimer s disease and dementia. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE: 451 North High Street East Haven, CT 06512	

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 10/3/22 identified Resident #16 was admitted for long term care. Intervention included to continue to keep family involved and updated regarding health and well being. The Social Services Admission assessment dated [DATE] was completed. Review of the clinical record from 10/5/22- 3/14/24 did not reflect quarterly or annual assessments by the social worker in December 2022, March 2023, June 2023, September 2023, December 2023, and March 2024. The clinical record identified progress notes for 3/8/23 and 7/25/23, but no assessments. The significant change of condition MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, was frequently incontinent of bladder and always incontinent of bowel and required extensive assistance with bed mobility, toileting, and personal hygiene. Additionally, needed limited assistance with transfers, dressing, and locomotion on and off the unit. The Social Services Quarterly assessment dated [DATE] identified as of 3/14/24 was blank. Interview and clinical record review with SW #2 on 3/12/24 at 11:33 AM indicated she or SW #1 must do the admission, quarterly, annual and change of condition assessments and progress notes for the residents. After clinical record review for Resident #16, SW #2 indicated she had not done the assessments July and October 2023 and January 2024. SW #2 indicated that either SW 32 or herself should have don them but did not have time to get them done. SW #2 indicated that she was on maternity leave was November of 2021 through May of 2022 and SW #1 was out from September of 2023 through January/February of 2024. SW #2 indicated that there was only 1 person here so 1 person cannot do this facility. SW #2 indicated she was responsible to do the quarterly assessments and did not do the social worker assessments in July 2023, October 2023, or January/February 2024. SW #2 indicated the other social worker was out and she informed the Administrator she needed assistance and was given a trainee. SW #2 indicated the facility started a new assessment for the social workers to do for the quarterly assessments in the electronic medical records which started in October 2023, but she had not utilized it. Interview and clinical record review with SW #1 on 3/14/24 at 9:45 AM identified that Resident #16 the admission assessment was completed on 10/5/22. SW #1 indicated the admission assessment was the only assessment completed for Resident #16. SW #1 indicated that on 1/31/23 she opened to write a progress note but did not complete it and lock it until 3/8/23. SW #1 indicated she had opened another progress note on 4/13/23 and did not complete it until 7/25/23. SW #1 indicated the quarterly assessments not done were 1/31/23 (a progress note), 4/13/23 (a progress note), 11/10/23, 2/10/24 were not completed. SW #1 indicated the progress notes are not equivalent to what she should be doing for an assessment. 3. Resident #31 was admitted to the facility on [DATE] with diagnoses that included stroke and dementia. The Admission assessment dated [DATE] did reflect a social services assessment was completed. The care plan dated 2/17/21 identified Resident #31 was admitted for long term placement. Interventions included to have 1:1 social service visits to see how resident is doing and to see if there is anything that the resident may need to help the resident with adjusting to this new environment. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record for Resident #31 from 1/27/21-3/14/24 only reflected 1 social worker assessment completed on 1/27/21. The clinical record did not reflect any additional quarterly or annual assessments completed by a social worker. Interview and clinical record review with SW #1 on 3/14/24 at 9:55 AM identified that Resident #31 Admission assessment was completed on 2/3/21. SW #1 indicated that the 2/15/21 quarterly progress note was completed late on 3/12/21. SW #1 indicated that the social worker assessments were not completed for an annual in January 2022, January 2023, and January 2024. SW #1 indicated the quarterly assessments not completed were April 2022, July 2022, October 2022, July 2023, and October 2023. SW #1 indicated they were not completed because she had been out on leave for an extended period and prior to her the other social worker had been out for an extended amount of time. SW #1 indicated it is hard to keep up with 2 social workers with all the admissions and discharges every week and impossible with only 1 at the facility. SW #1 indicated it is also confusing when MDS has a quarterly last month for a resident and then again, this month has another quarterly. SW #1 indicated that the MDS office is putting in more quarterly's than needed and more frequently, so we are not getting them all done. Additionally, SW #1 indicated MDS is putting in more MDS's than needed and now she is required to do 2 MDS's every quarter for every resident for reimbursement reasons. Interview with the Administrator on 3/14/24 at 10:49 AM indicated that she was aware that the social worker assessments were not being done timely and that she was looking to hire a new social worker to assist getting the assessments completed. Social Worker Job Description identified the social worker was responsible to be knowledgeable of admissions and discharges procedures and be familiar with resident rights and documentation requirements in accordance with OBRA regulations and guidelines. The social worker must meet requirements as stated in the public health code. The social worker was responsible for documenting initial and biopsychosocial assessments of residents, interim notes regarding changes, and MDS sections and quarterly, annual, significant changes, and documents the discharge plan. Although requested, a facility policy for social worker assessments and documentation policy it was not provided.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 3 residents (Resident #10, #16 and #31) reviewed for care planning, the facility failed to ensure the quarterly MDS assessments were transmitted timely. The findings include: 1. Resident #10 was admitted to the facility with diagnoses that included atrial fibrillation, anxiety, major depression, and paranoid schizophrenia. The significant change in condition MDSassessment dated [DATE] identified Resident #10 had moderately impaired cognition and required maximum assistance with bathing, dressing, personal hygiene and total dependence for toileting. Assessment signed as completed on 11/24/23. The quarterly MDS assessment dated [DATE] identified Resident #10 had moderately impaired cognition and required maximum assistance with bathing, dressing, personal hygiene and total dependence for toileting. Assessment signed as completed on 2/26/24. Interview with RN #6 (Director of MDS coordinators) on 3/14/24 at 9:10 AM indicated she was responsible to make sure the admission, quarterly, annual and change in condition MDS's were completed by the appropriate department heads and transmitted on time. Review of the clinical record for Resident #10, RN #6 indicated that the change of condition MDS with ARD of 10/20/23 must be completed within 14 days by 11/2/23. RN #6 indicated it was not completed until 11/24/23 (22 days late) and was not transmitted until 12/3/23 (14 days late). RN #6 indicated the MDS with ARD of 1/19/24 was to be completed by 2/1/24 but was not completed until 2/26/24 (25 days late) and was not transmitted until 2/27/24 (14 days late). 2. Resident #16 was admitted to the facility with diagnoses which included Alzheimer s disease and dementia. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition and required total assistance with bathing, dressing, personal hygiene, and toileting. Assessment signed as completed on 12/20/23. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition and required total assistance with bathing, dressing, and toileting. Assessment signed as completed on 3/13/24. Interview with RN #6 on 3/14/24 at 9:15 AM indicated that Resident #16 had an MDS dated [DATE] that was supposed to be completed by 11/24/23. RN #6 indicated that it was not completed until 12/20/23 (26 days late) and was not transmitted until 12/21/23 (12 days late). RN #6 indicated the MDS dated [DATE] was supposed to be completed by 2/24/23 but was not completed until 3/13/24 (18 days late) and has not been transmitted yet (5 days late). 3. Resident #31 was admitted to the facility on [DATE] with diagnoses which included stroke and dementia. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The quarterly MDS assessment dated [DATE] identified Resident #31 had severely impaired cognition and required total assistance with bathing, dressing, and toileting. Assessment signed as completed on 1/24/23. The quarterly MDS assessment dated [DATE] identified Resident #31 had severely impaired cognition and required total assistance with bathing, dressing, and toileting. Assessment signed as completed on 11/17/23. The annual MDSassessment dated [DATE] identified Resident #31 had severely impaired cognition and required total assistance with bathing, dressing, and toileting. Assessment signed as completed on 1/11/24. The quarterly MDS assessment dated [DATE] identified Resident #31 had severely impaired cognition and required total assistance with bathing, dressing, and toileting. Assessment was not signed off as completed as of 3/14/24. Interview with RN #6 on 3/14/24 at 9:20 AM indicated that the MDS dated [DATE] was not completed until 1/24/23 (8 days late). RN #6 indicated the MDS dated [DATE] was supposed to be completed by 10/31/23 but was not completed until 11/17/23 (17 days late). RN #6 indicated the annual MDS dated [DATE] was supposed to be completed by 12/9/23 but was not completed until 1/11/24 (33 days late) and not transmitted until 1/13/24 (26 days late). RN #6 indicated the MDS dated [DATE] was supposed to be completed by 3/7/24 and still was not completed yet nor transmitted. RN #6 indicated she was aware that the MDS's were not getting completed or transmitted timely. RN #6 indicated it was due to the OSA (state optional MDS assessment) for increased payment her workload has doubled. RN #6 indicated that now they are doing 2 MDS's for every resident to receive more money since 10/1/23. RN #6 indicated that she has spoken with the Administrator in January 2024 about not being able to get all the MDS's done and transmitted timely. RN #6 indicated they have tried to get per-diem MDS coordinators that can work remotely from home but that hasn't worked. RN #6 indicated there was no policy for MDS's and transmission from the facility, but they follow the state and federal requirements. Interview with the Administrator on 3/14/24 at 10:49 AM indicated she was aware that the MDS's were not being completed timely and that the MDS's were not being transmitted timely. The Administrator indicated they had hired a per diem MDS coordinator but now she was in process of hiring two more MDS coordinators, one for 8 or more hours a week and one to help on the weekends. Although requested, a facility policy for MDS assessments requirements and transmission of MDS's was not provided.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation and interviews for 1 of 5 residents (Resident #5) reviewed for PASARR, the facility failed to ensure the PASARR was updated when there was a change in condition. The findings include: Resident #5 PASARR dated 3/23/17 identified a diagnosis of schizoaffective disorder and major depression. PASARR indicated Resident #5 does not have a diagnosis of dementia or Alzheimer's disease. Resident #5 was admitted to the facility on [DATE] with diagnoses which included dementia, major depression, and schizoaffective disorder. The hospital discharge summary dated 6/24/21 identified Resident #5 had a diagnosis of schizoaffective disorder, diabetes, and dementia. A physician's order dated 6/24/21 directed Divalproex (used for schizoaffective disorder) 750 mg extended release in the morning and Divalproex 1000 mg delayed release at bedtime, Perphenazine (used for schizoaffective disorder) 4 mg tablet twice a day, Duloxetine (depression) 90 mg daily. The physician admission note dated 6/25/21 identified Resident #5 had a diagnosis of dementia, schizoaffective disorder, diabetes, and hypertension. The admission MDS assessment dated [DATE] identified Resident #5 had moderately impaired cognition and required extensive assistance for bed mobility, dressing, toileting, and personal hygiene. Resident #5 was totally dependent on staff for transfers. Additionally, Resident #5 had a diagnosis of dementia. The care plan dated 10/3/22 identified a positive level of care due to psychiatric diagnosis. Interventions included mental health counseling, recreation activities, and ongoing evaluation of effectiveness of psychotropic medications. The psychiatric provider dated 10/26/22 indicated Resident #5 was seen for follow up for schizoaffective and dementia with behaviors. Interview with SW #2 on 3/12/24 at 9:01 AM indicated she was responsible to check the PASARR on admission and if a resident needed a Level 2 . SW #2 indicated she was also responsible to update PASARR if a resident received a new psychiatric diagnosis or a new diagnosis of dementia. SW #2 indicated that Resident #5 had PASARR completed on 3/23/17 at another facility with a diagnosis of schizoaffective disorder and major depression. SW #2 indicated Resident #5 was referred for a level 2 on 3/17/17 and had long term care approval. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #2 on 3/12/24 at 9:30 AM indicated Resident #5 did not have a diagnosis of dementia on the admission PASARR dated 3/17/21 and when there was a change in condition with a new diagnosis of dementia, she should have updated Ascend with a new PASARR level 2. After clinical record review, SW #1 indicated that when Resident #5 was admitted to the facility she should have submitted a new PASARR with the new diagnosis of dementia so Resident #5 would have received an exclusion from PASARR, but she missed it. SW #2 indicated that she was responsible for reviewing the hospital paperwork, but she had missed the diagnosis of dementia on it. SW #2 indicated Resident #5 was seen by the psychiatric provider on 10/26/22 who gave Resident #5 the diagnosis of dementia and she could have updated Ascend then of the diagnosis, but she missed it, and the psychiatric provider did not tell her. SW #2 indicated that she had missed the diagnosis of dementia on admission and on 10/26/22 so she will update Ascend today. SW #2 indicated that they did not have a policy regarding Ascends. Interview with the Administrator on 3/12/24 at 10:26 AM indicated the Social Worker was responsible to update Ascend of any changes such as the diagnosis of dementia on admission or when there is a new diagnosis. The Administrator indicated that the diagnosis on admission 6/24/21 did not have dementia listed. The Administrator indicated that when the psychiatric APRN added the diagnosis of dementia it was not communicated to the Social Worker. Although requested, a facility policy for PASARR was 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** 42117 43032 46040 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident #10 and #48) reviewed for accidents, the facility failed to ensure the neurological assessments were completed after multiple falls and for 1 resident (Resident #16) reviewed for hospice, the facility failed to ensure there was a physician order for hospice services and 1 of 2 residents (Resident #66) reviewed for pressure ulcers, the facility failed ensure an RN assessment was completed for a newly identified skin blister and for 1 of 7 residents (Resident #104) reviewed for nutrition, the facility failed to follow the physician's orders to obtain repeated labs for a resident with an abnormal blood count and for 2 of 7 (Resident #2 and Resident#315) reviewed for nutrition, the facility failed to obtain weights according to facility policy. The findings include: 1. Resident #10 was admitted to the facility with diagnoses which included paranoid schizophrenia, schizoaffective disorder, and atrial fibrillation. The significant change in condition MDS dated [DATE] identified Resident #10 had moderately impaired cognition and required extensive assistance with dressing and personal hygiene and requires total assistance with toileting. Additionally, has had 2 falls since admission. A physician's order dated 10/26/23 directed to administer Coumadin 3.5 mg in the evening. The care plan dated 10/30/23 identified fall risk. Interventions included to ensure frequently used items are within resident's reach, encourage resident to call for assistance, and encourage resident to ask and wait for staff assistance for transfers and toileting. The Reportable event form dated 11/7/23 at 12:45 PM identified Resident #10 had an unwitnessed fall while throwing away a cup and slid from the bed to the floor. Resident #10 had socks on but was not wearing grippy socks. The nurse fed resident lunch from 12:15 -12:35 M. Resident #10 had no injury. The neurological assessment form did not reflect that the neurological assessments were conducted. The Reportable event form dated 12/18/23 at 7:15 PM identified Resident #10 had an unwitnessed fall. Resident #10 was observed sitting on the floor in residents' room next to the bed stated he/she was reaching to turn off the light and slipped out of bed. Resident #10 had no injury. The neurological assessment form did not reflect that the neurological assessments were conducted. Reportable event form dated 12/22/23 at 3:20 PM identified Resident #10 had an unwitnessed fall. Resident #10 was last seen in bed and found on the floor. Resident #10 had no injury. The neurological assessment form identified did not reflect that the neurological assessments were completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reportable event form dated 1/17/24 at 10:30 AM PM identified Resident #10 had an unwitnessed fall. Resident #10 stated he/she fell on his/her knees trying to reach for a cup on his side table. Bruise to right side of shoulder blade, abrasions noted to both knees, and an open area noted to right buttocks. Interview with DNS on 3/13/24 at 1:15 PM identified any unwitnessed fall the neurological assessment must be done. The DNS indicated that Resident #10 has moderate impairment cognition, and she would expect the neurological assessments to be done and completed per the facility policy. After clinical record review, the DNS indicated that the 11/17/23, 12/18/23, 12/22/23 and 1/17/24 were not done per the facility policy. The DNS indicated that the charge nurses were responsible for completing the neurological assessments and when the assessments were completed, they were to hand the forms in to her. The DNS indicated the neurological assessments are done on paper and not in the electronic medical record. The DNS indicated she would prefer it if the nurses would have to document the neurological assessments in the electronic medical record, so papers don't get lost. The DNS indicated the neurological assessments were very important so the nurses could pick up on any slight changes as soon as possible and notify the supervisor to do an evaluation and then update the provider to send the resident to the hospital. Review of the facility Falls Minimizing Risk of Injury Policy identified a resident that experiences an un-witnessed fall and is unable to accurately verbalize if he/she hit head due to cognition status will have neurological checks instituted. Each time a resident falls an accident and incident report will be completed and neurological monitoring will be documented for 72 hours. Review of the facility Neurological Policy identified a resident that experiences an unwitnessed fall will have neurological checks instituted. The nurse will explain to the resident to report any symptoms such as blurred vision, headache, drowsiness, vomiting, slurred speech, weakness, or paralysis and numbness or tingling. A neurological flow sheet will be instituted by the nurse. The checks will be completed as follows: every 15 minutes for 1 hour, every hour for 4 hours, every 4 hours for 24 hours, and every shift for 48 hours. The neurological flow sheet shall include the following documentation: date, time, level of consciousness, pupillary response, strength and sensation of all extremities, and vital signs. The nurse will observe and listen to speech for appropriate clarity, expressiveness, and receptive components. The nurse will assess orientation to person, place, and time. 2. Resident # 48 was admitted to the facility on [DATE] with diagnoses which included dementia, repeated falls, and psychophysical visual disturbances. Review of a facility Accident and Incident(A&I) report dated 9/2/23 at 3:15 PM identified Resident #48 had an unwitnessed fall, and Resident #48 was unable to provide a clear description of what happened. The Accident and Incident report included documentation that neurological checks were initiated at 3:30 PM. Review of a facility A&I report dated 9/2/23 at 7:30PM identified Resident #48 had 2nd unwitnessed fall and was observed sitting on the floor against the wall of his/her room. The report identified Resident #48 had 2 abrasions to the mid back and hit his/her head. The A&I report identified that Resident #48 was sent to the hospital for evaluation at 8:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 9/2/23 at 9:11 PM completed by RN #10 identified that Resident #48 had no change in condition. The note further identified that Resident #48 was admitted to the facility on [DATE] at 2:55 PM and fell at 3:15PM onto his /her buttocks his/her buttocks but did not hit his/her head, was confused at baseline, and was unable to follow simple commands, and was oriented to his/her room prior to the fall. A nursing note dated 9/2/23 at 9:51 PM completed by RN #10 identified that Resident #48 was admitted to the facility on [DATE] at 2:55 PM and fell earlier 3:15PM. The note further identified that Resident #48 fell on his/her buttocks and hit his/her head, was confused at baseline, and was unable to follow simple commands. The note identified Resident #48 was sent to the hospital for evaluation. Review of the clinical record failed to identify any additional documentation related to Resident #48's fall on 9/2/23 at 7:30 PM. The care plan dated 9/4/23 identified Resident # 48 had a history of falls due to multiple risk factors. Interventions included offering toileting and incontinent care during first rounds on the 3PM- 11PM shift. The admission MDS dated [DATE] identified Resident # 48 had severely impaired cognition, was frequently incontinent of bowel and bladder and required the assistance of one to two staff members with transfers, toileting, and dressing. The MDS also identified Resident #48 had 2 or more falls with injury since admission to the facility. Review of a facility A&I report dated 9/8/23 at 2:30 PM identified Resident #48 had an unwitnessed fall that resulted in a 1 cm x 2 cm laceration to the left side of the forehead. The report included neurological checks completed at 2:30 PM and again at 2:45 PM. The report identified Resident #48 was sent to the hospital for evaluation at 3:00PM. The 9/8/23 neurological check documentation identified Resident #48 was at the hospital beginning at 3:00 PM. A nursing note dated 9/8/23 at 8:50 PM by RN #10 identified Resident #48 returned to the facility at 8:35 PM following hospital evaluation for a fall. The note further identified Resident #48 was observed to have small hematoma where he/she hit her head. Review of the clinical record for Resident #48 failed to identify any documentation that neurological checks were completed following his/her return to the facility on [DATE] at 8:35 PM. Review of a facility A&I report dated 9/8/23 at 10:00 PM identified Resident #48 had an unwitnessed fall and was found on the floor of his/her room bleeding from the head. The report identified that Resident #48 was sent to the hospital for evaluation at 10:10 PM. Review of the clinical record failed to identify any documentation related to vital signs following Resident #48's readmission to the facility on [DATE] or subsequent unwitnessed fall at 10:00 PM. Review of the clinical record identified Resident #48 returned to the facility from the hospital on 9/9/23 at 5:30 AM and neurological checks were initiated at 7 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility A&I report dated 9/11/23 at 3:30 PM identified Resident #48 had an unwitnessed fall and was found lying next to his/her wheelchair. The report identified Resident #48 was unable to describe what happened and complained of right ankle pain and was sent to the hospital for evaluation. Review of the clinical record failed to identify any documentation related to initiation of neurological checks or the time Resident #48 was sent to the hospital for evaluation of the unwitnessed fall on 9/11/23. Review of the clinical record identified Resident #48 was hospitalized from 9/11-9/15/23 for urinary tract infection. Review of a facility A&I report dated 9/22/23 at 6:30 PM identified Resident #48 had an unwitnessed fall and was found lying on the ground next to his/her roommate's bed. The report identified Resident #48 was unable to describe what happened, complained of head pain, and was sent to the hospital for evaluation. Review of the clinical record identified that Resident #48 returned to the facility from the hospital on 9/23/23 at 5:55 AM. Review of the clinical record failed to identify any neurological checks were conducted following Resident #48's unwitnessed fall on 9/22/23 at 6:30 PM until 9/23/23 at 5:00 PM. Review of the neurological check documentation identified Resident #48 out to the hospital from 9/22/23 at 6:15 PM until 9/23/23 at 5:55 AM. Review of the clinical record and interview on 3/13/23 at 2:15 PM with the DNS identified the facility policy for a resident with an unwitnessed fall included a nursing assessment and initiation of neurological checks for a total of 72 hours. A review of Resident #48's clinical record and A&Is were completed with the DNS, who identified that there had been issues related to RN #10's clinical documentation and she was aware of the issue. The DNS also identified that the documentation in the clinical record related to the nursing assessments and falls on 9/2/23 appeared to be duplicate documentation of the fall that occurred at 3:15 PM. The DNS identifed that 2 comprehensive RN assessment should have been completed following Resident #48's falls 9/2/23 with clear documentation related to the time of each fall. The DNS also identified that updated vital signs should be obtained with a nursing assessment, and that neurological checks should be completed per facility policy, regardless of whether a resident is sent to the hospital for evaluation. The DNS identified that neurological checks should have been completed every 15 minutes for the first hour, then every hour for 4 hours, every 4 hours for 24 hours and every shift until the 72 hours was reached. The DNS identified that the nursing staff may have been confused on when Resident #48 needed to have neurological checks done, since there were multiple falls within the same day at times, but the policy would be to restart neurological checks with each new unwitnessed fall or fall with head injury. Although attempted, an interview with RN #10 was not obtained. The facility policy on falls directed that residents who experience an unwitnessed fall and were unable to accurately verbalize if he/she hit their head due to cognitive status, or if there was any type of head injury, would have neurological checks instituted. The policy also directed that after a resident fall a RN assessment would be completed. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on neurological checks directed that any resident who experienced an unwitnessed fall and was unable to accurately verbalize if he/she hit their head due to cognitive status or had any type of head injury would have neurological checks instituted. The policy further directed neurological sheets would be instituted by the nurse and checks would be completed as follows: every 15 minutes for the first hour; every hour for 4 hours; every 4 hours for the next 24 hours, and then every shift for 48 hours after that. The policy also directed that neurological checks should include vital signs, and that the resident's blood pressure, pulse, and respirations would be check for any significant changes. The facility policy on nursing documentation directed the purpose of the policy was to capture any changes in condition that required a licensed staff assessment of a resident and should provide an account of any changes in condition, current assessments, and any concerns that could alter the resident's current plan of care. The policy further directed that nursing documentation should be clear, concise, and specific. 3. Resident #16 was admitted to the facility with diagnoses which included Alzheimer's disease and dementia. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition and required extensive assistance with dressing, toileting, and personal hygiene. Additionally, did not have hospice services currently. The social worker progress note dated 7/18/2023 at 1:19 PM indicated she had meet with resident's representative on 7/17/23. Discussed possibility of hospice eligibility for resident per the physician's assistant recommendation. Discussed goals of care, resident representative was agreeable to referral. At resident representatives request referral made to Hospice Agency today on 7/18/23. Hospice evaluation is pending. The social worker progress note dated 7/21/2023 at 12:18 PM indicates that Resident #16 was evaluated by hospice and admitted on their services effective on 7/20/23. Review of the physician orders dated 7/1/23-3/13/24 did not reflect a physician's order for a consult with hospice or a hospice evaluation and treatment order was in place. Interview with the DNS on 03/14/24 11:18 AM indicated there should be an initial physician's order for hospice to evaluate and treat and then another physician's order for when Resident #16 was picked up by hospice services. The DNS indicated that nursing was responsible to put in the orders for hospice. The DNS indicated that Resident #16 was picked up by hospice as of 7/20/23 per the social worker note. The DNS indicated it was managed by social workers and resident is on hospice services. After clinical record review, the DNS indicated that she did not see a physician order from July 2023 until today 3/14/24 and nursing was responsible to put order in. After surveyor inquiry, a physician's order dated 3/14/24 at 11:39 AM as a late entry for 7/20/23 directed for a hospice evaluation completed on 7/20/23 and accepted. Interview with the DNS on 3/14/24 at 11:55 AM indicated she had spoken via phone with the physician assistant and obtained an order for hospice services for Resident #16. (continued on next page)

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 03/14/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Hospice Services Policy identified the social worker will assist the resident and/or resident representative per facility policy regarding hospice resources. The social worker will be the liaison for the resident and/or resident representative, facility, and the hospice service. If the resident/resident representative chooses in house hospice services, the attending physician will be notified and a physician's order will be obtained by nursing for a hospice evaluation. 4. Resident #66 was admitted to the facility on [DATE] with diagnoses which included dementia, severe protein-calorie malnutrition, and adult failure to thrive. The annual MDS assessment dated [DATE] identified Resident #66 had severely impaired cognition, was at risk for developing pressure ulcers/injuries, was always incontinent of bowel and bladder, and was dependent on staff for chair/bed-to-chair transfers and rolling left to right. The care plan dated 1/26/24 identified Resident #66 was at risk for alterations in skin integrity related to incontinence of bowel and bladder, severe malnourishment, and failure to thrive. Interventions included to inspect skin for signs and symptoms of breakdown including bruising, rashes and infection when providing care and report any issues, keep skin clean and dry, apply lotions and barrier creams as ordered, and provide wound care and adjust wound care treatments as ordered. The nurse's note dated 2/9/24 at 11:11 PM identified that a superficial dime sized area was observed on Resident #66's left hip, the nursing supervisor was notified and a note was placed in the APRN's communication book. The nurse's notes dated 2/9/24 through 2/14/24 failed to identify an RN assessment of Resident #66 left hip area was documented in the clinical record. The nurse's note dated 2/15/24 at 3:40 PM identified Resident #66 was seen by the wound MD; an open blister was noted to the left hip and new orders for bordered Hydrogel every 3 days was obtained. The wound specialist progress note dated 2/15/24 identified Resident #66 had a full thickness blister with a status of not healed, wound measurements were 1cm x 1 cm x 0 cm, a scant amount of sanguineous drainage was noted, and the peri-wound skin texture, moisture and color were normal. Physician's orders directed to apply bordered Hydrogel every 3 days and to change as needed for soiling, saturation, or accidental removal. The wound specialist progress note dated 2/29/24 identified the blister to Resident #66's left hip had received an outcome of resolved. Interview and clinical record review with the DNS on 3/14/24 at 8:50 AM, failed to provide documentation that an RN assessment was completed following the identification of a new skin blister. The DNS indicated that she would expect an RN assessment to be completed by the nursing supervisor following the recognition of a new wound and for the RN to initiate a wound tracking sheet. The DNS identified that documentation of the wound assessment should be in the resident's clinical record and should include if the wound was pressure or non-pressure related, size, shape, drainage, and measurements. The DNS further identified that while the wound nurse had assessed the wound on 2/13/24 and started tracking the wound; she would have expected to see an assessment documented in the clinical record from the nursing supervisor when the wound was first recognized. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although attempted, an interview with the 3-11 PM nursing supervisor (RN #5) was not obtained. The Wound Prevention Interventions for Residents policy directs that interventions are directed toward minimizing and/or eliminating any negative effects of the causal/contributing factors such as pressure, moisture, friction/shear, and poor nutrition for all residents admitted to the facility, and when an abnormal skin area is observed, it will immediately be reported to a licensed nurse who will assess and follow through as indicated per protocol. The Pressure Ulcer Prevention policy directs that a comprehensive skin assessment be conducted with every risk assessment and if a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in the skin. The Change in Resident Condition/Family/MD Notification policy directs when there is a significant change in the condition of a resident's physical, mental, or emotional status the resident's attending physician and responsible party shall be notified, and an RN assessment will be conducted. 5. Resident #104 was admitted to the facility on [DATE] with diagnoses which included diabetes type 2, neutropenia, chronic lymphocytic leukemia and was readmitted [DATE]. The annual MDS assessment dated [DATE] identified Resident # 104 had intact cognition, required substantial assistance with showering or bathing, and was independent with eating, oral hygiene, toileting, dressing, and personal hygiene. The annual MDS also identified Resident #104 had neutropenia (a blood disorder impacting immunity). The care plan dated 1/12/24 identified a focus on chronic kidney disease with interventions that included monitoring labs and to report abnormal labs to physician or APRN. A consultation report from oncology on 1/18/24 directed to continue Filgrastim (a bone marrow stimulant) and schedule a complete blood count (CBC) once per week. The consultation was reviewed by APRN #1 on 1/23/24. The nurse's note written by LPN #10 dated 1/18/24 at 5:56 PM identified that Resident #104 should continue with Filgrastim and have a CBC drawn once per week. The labs for a CBC drawn on 1/23/24 identified the WBC (white blood count) was 2.2 therapeutic range is 3. 8-10.8, and the absolute neutrophil count was 946 the therapeutic range is 1500-7800. An interview with APRN #1 on 3/12/24 at 1:45PM noted the Filgrastim was ordered by oncology. APRN #1 indicated that she would expect that the facility monitors for infection, bleeding, loose stools, and monitor labs. She further identified, Resident #104 sees the oncologist frequently, and the facility sends labs. APRN #1 also identified a resident on Filgrastim should have lab monitoring minimally on a monthly basis. Interview and clinical record review with the DNS on 3/13/23 at 3:45 PM identified it is her expectation that physicians' orders are followed . (continued on next page)

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	075389	A. Building B. Wing	03/14/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record and lab review with the Medical Director on 03/13/24 at 04:09 PM identified if oncology requested a weekly CBC, the CBC should have been continued weekly until the absolute neutrophil's exceeded 1000. When disclosed the labs on 1/23/24, identified an absolute neutrophil count of 946 (the therapeutic range is 1500-7800), the Medical Director indicated the labs should have been done weekly. Although requested, a facility policy on neutropenic monitoring was not provided. 6. Resident #2 was admitted to the facility on [DATE] with diagnoses which included surgical aftercare following a right shoulder joint replacement, hypothyroidism and hyperlipidemia. A physician's order dated 2/25/24 directed to obtain an admission height and weight for Resident #2. The care plan dated 2/29/24 identified Resident #2 had a potential for nutritional decline due to recent hospitalization . Interventions included monitoring weights as ordered. The admission MDS assessment dated [DATE] identified Resident # 2 had intact cognition, was continent of bowel and bladder and required partial assistance with toileting, dressing, and was independent with eating. A physician order dated 3/4/24 directed that Resident #2 required weekly weights for 4 weeks. A review of the clinical record failed to identify any documentation related to weights for Resident #2. 7. Resident # 315 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection, history of falls, and hypertension. The care plan dated 2/26/24 identified Resident #315 had potential for nutritional decline due to a history of morbid obesity and celiac disease. Interventions included obtaining weights as ordered. A physician's order dated 2/29/24 directed that Resident #315 required weekly weights every evening shift on Thursday for 4 weeks. Review of the clinical record identified that Resident #315 had a weight of 220.6 lbs on 2/29/24, 4 days after admission. Further review of the clinical record failed to identify any additional weights documented for Resident #315. The admission MDS assessment dated [DATE] identified Resident # 315 had intact cognition, was always incontinent of bladder and required the assistance of two staff members with transfers, toileting, and was independent with eating. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MD #1 (Medical Director) on 3/13/24 at 11:10 AM identified that it was the policy of the facility to obtain weights on all residents upon admission with the initial nursing assessment. MD #1 identified that from admission, the weights would then depend on the orders for the resident, with some residents only requiring monthly weights. MD #1 further identified that some residents have orders for more frequent monitoring, including weight loss, and that his expectation would be weights would be obtained on admission and per the physician's orders. Interview with the Dietician on 3/13/24 at 1:41 PM identified that the nursing staff was responsible to ensure weights were obtained on admission for all residents of the facility. The Dietician identified that she completed nutritional assessments on newly admitted residents, and that if she did not see an admission weight on the resident at the time of assessment, she would add an order for weekly weights for 4 weeks for the physician or APRN to sign off on to ensure weights would be done. The Dietician identified that she would not follow up on the orders to ensure they were done but would follow up on any documented weights if there were issues, and that she was not aware that no weights had been obtained for Resident #2, and only one weight was obtained for Resident #314. The Dietician identified that the facility did not use weight books and only documented weights within the electronic clinical record. Interview with the DNS on 3/13/24 at 1:54 PM identified that the facility policy was for weights to be obtained upon admission as part of the initial assessment of the residents. The DNS identified that while it would be ideal to obtain the weight when the resident comes into the facility, there are times when it is not done right away due to the time of evening the resident arrives, or if the resident does not feel up to it and needs to rest. The DNS identified that in this case, the weight should be done the following day within 24 hours. The DNS identified she was unsure why the weights were not done per the physician orders, but that they should have been completed within 24 hours of admission and then weekly for Resident #2 and Resident #315. The facility policy on weight monitoring directed that residents would be weighed upon admission and then every week for 4 weeks and then monthly, unless otherwise indicated by the physician's order or recommendation of the dietician.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observations, clinical record review, facility documentation, facility policy, and interviews for 1 of 7 residents (Resident #94) reviewed for nutrition, the facility failed to ensure that weights were monitored per physician's order for a resident with a significant weight loss. The findings include: Resident # 94 was admitted to the facility on [DATE] with diagnoses which included stroke, hypertension, and diabetes. The APRN note dated 3/6/23 identified Resident #94 did not require medication or blood glucose monitoring for diabetes. A physician's order dated 3/9/23 directed for weekly weights and vital signs to be obtained every Friday day shift. The quarterly MDS assessement dated 3/16/23 identified Resident # 94 had moderately impaired cognition, and required supervision with eating. The care plan dated 3/16/23 directed that Resident #94 had a potential for nutritional decline related to medical history. Interventions included obtaining weights as ordered. The nutritional assessment dated [DATE] identified that Resident #94 had a current weight of 149.6 lbs., had weighed 156 lbs. 30 days prior, and was at low nutritional risk. Review of the clinical record identified the following weights documented in Resident #94's clinical record beginning 3/2023: 03/04/2023 14:25 149.6 lbs. 03/15/2023 14:39 149.6 lbs. 03/24/2023 14:52 149.8 lbs. 04/12/2023 11:39 149.5 lbs. 05/04/2023 10:05 148.4 lbs. 06/09/2023 09:12 145 lbs. 07/10/2023 10:53 142.8 lbs. 08/04/2023 14:58 138.6 lbs. 08/25/2023 13:20 137 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 8/9/23 directed Resident #94 required an 8 oz diabetic supplement every day shift due to weight loss. A nutritional assessment dated [DATE] identified that Resident #94 had a weight of 137 lbs on 8/25/23, and had a 7.4% total loss since 3/4/23, 6 months prior. The assessment identified that Resident #94 had a weight loss trend over 6 months and had an order for weekly weight monitoring. The assessment further identified that Resident #94 was at increased nutritional risk for inadequate oral intake and required nutritional supplements. Review of the clinical record identified the following weights for Resident #94 following the 9/6/23 nutritional assessment: 09/10/2023 13:46 139.6 lbs. 11/12/2023 10:53 128.8 lbs. 12/01/2023 15:49 126.6 lbs. A physician's order dated 12/6/23 directed Resident #94 required 8 oz house supplements twice daily after lunch and dinner for weight loss. A nutritional assessment dated [DATE] identified that Resident #94 had a weight of 127.7 lbs on 1/6/24, and had a 10.6% total loss since 7/10/23, 6 months prior. The assessment identified that Resident #94 had a weight loss trend over 6 months and had an order for weekly weight monitoring. The assessment further identified that Resident #94 had a significant unintentional weight loss over the prior 6 months and that weight had been stable x 3 months. Review of the clinical record identified Resident #94 had a weight of 128 lbs. on 2/8/24, with no additional weights documented or recorded after this date. Interview with MD #1 (Medical Director) on 3/13/24 at 11:10 AM identified it was the policy of the facility to obtain weights on all residents upon admission with the initial nursing assessment. MD #1 identified that from admission, the weights would then depend on the orders for the resident, with some residents only requiring monthly weights. MD #1 further identified that some residents have orders for more frequent monitoring, including weight loss, and that his expectation would be weights would be obtained on admission and per the physician's orders. Review of the clinical record and interview with the DNS on 3/13/24 at 2:07 PM identified that the facility policy was for weights to be obtained upon admission as part of the initial assessment of the resident, weekly for 4 weeks and then monthly unless the physician's order directed otherwise. The DNS identified that she was aware Resident #94 had a history of weight loss and she had discussed this with the Dietician, but was not aware Resident #94 had weekly weight orders in place and was unsure why the weights were not done per the physician orders. Subsequent to surveyor inquiry, review of the clinical record identified Resident #94 had a weight of 124.1 lbs documented on 3/13/24 at 10:46 PM, a 3.9 lb or 3% loss from 5 weeks prior on 2/8/24, and a 15.5 lb or 11.1% weight loss from 6 months prior on 9/10/23. (continued on next page)

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	075389	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 3/14/24 directed Resident #94 required 8 oz house supplements twice daily after breakfast and lunch, and to offer evening snacks. The facility policy on weight monitoring directed that residents would be weighed upon admission and then every week for 4 weeks and then monthly, unless otherwise indicated by the physician's order or recommendation of the dietician. The policy further directed that if there was a 5 lb weight discrepancy (plus or minus) a reweight should be obtained and compared to the previous weights to determine if the resident had a 5% weight change over 30 days or 10 % weight change over 180 days

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #49 and #268) reviewed for respiratory care, the facility failed to ensure (Resident #49)respiratory equipment was labeled, dated, and stored per policy when not in use and (Resident # 268) failed to maintain BiPaP tubing in a sanitary manner. The findings include: 1. Resident #49 was admitted to the facility with diagnoses which included dementia, hypertension, and Covid-19. The quarterly MDS assessment dated [DATE] identified Resident #49 had severely impaired cognition and requires total assistance with oral hygiene, bathing, and personal hygiene. The care plan dated 2/13/24 identified Resident #49 has pneumonia. Interventions included to use oxygen and oxygen saturation levels as ordered. Additionally, respiratory modalities per physician orders. A physician's order dated 2/13/24 directed to apply oxygen between 1-5 liters per minute to maintain oxygen level greater than 90% as needed and Albuterol Sulfate nebulizer solution 2.5mg per 3 ml inhale orally via nebulizer every 6 hours as needed for shortness of breath. Observation on 3/7/24 at 11:35 AM Resident #49 was lying in bed with a concentrator on left side of bed with oxygen tubing draped over the concentrator not labeled, dated, or bagged. The nebulizer machine with tubing and face mask was sitting on the nightstand on the right side of bed not labeled, dated, or bagged. Observation and interview with LPN #1 on 3/7/24 at 11:50 AM indicated the oxygen tubing and nebulizer tubing and mask were not labeled and dated and were not bagged. LPN #1 indicated that there should be a physician order for when the oxygen tubing and nebulizer tubing and mask were to be changed weekly. Review of the clinical record, LPN #1 indicated there was not an order for the changing of the oxygen tubing or for the nebulizer tubing and mask. Interview with RN #1 on 3/7/24 at 11:55 AM indicated the oxygen tubing and nebulizer tubing and mask were to be labeled and dated and to be changed every Sunday on 3:00 PM - 11:00 PM shift. After review of the clinical record, RN #1 indicated that there should be a physician order for the changing of the tubing's and mask, but it was not in the physician orders. Interview with the DNS on 03/13/24 at 1:30 PM indicated it was the responsibility of the night nurse to label, date, and change the oxygen tubing with nasal cannula and the nebulizer tubing and mask every Sunday 11:00 PM - 7:00 AM shift and placing the tape with the date on the tubing. After clinical record review, the DNS indicated there was not a physician's order to change the oxygen and nebulizer tubing and mask weekly. The DNS indicated that when any of the respiratory equipment such as the oxygen tubing or the nebulizer mask and tubing are not in use, they must be bagged to stay clean. (continued on next page)

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	075389	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Resident # 268 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), and dementia. The nursing admission assessment dated [DATE] identified Resident # 268 had impaired cognition, frequently required guidance for transfers, relies on support to propel manual wheelchair, and was admitted with a BiPaP machine to assist with breathing while asleep. The care plan dated 2/20/24 identified a focus on COPD with interventions which included providing CPAP as ordered and maintain equipment per protocol. A physician's order dated 2/16/24 directed to provide continuous oxygen at 3 L (liters per minute), and BiPaP settings 12/4 apply at sleep/remove in the morning related to COPD. A physician's order dated 2/18/24 directed to change and label oxygen tubing every week and as needed, for Sunday on the 11:00PM-6:00AM shift. Observation on 3/7/23 at 10:50AM identified the tubing associated with Resident #268's BiPaP was not dated nor contained in a bag. Interview with LPN #6 on 3/7/23 at 10:50AM identified the night shift should have updated the tubing and provided a bag. LPN #6 proceeded to discard the existing tubing, and stated she would secure new tubing when she leaves the room. Interview with the DNS on 3/13/24 at 3:20 PM identified the tubing is changed on the Sunday 11:00 PM-7:00AM shift and should have been labeled with the date assigned and bagged when not in use. The policy of BiPaP/CPAP care dated 6/19/2024, instructs the disposable tubing associated with the nebulizer should be changed every 2 weeks. Review of the facility Oxygen and Nebulizer Tubing Changes Policy identified to help prevent nosocomial respiratory infections while receiving oxygen therapy and/or nebulizer treatments. All oxygen tubing and nebulizer tubing including masks are for single resident use only. Oxygen and nebulizer tubing will be changed weekly, when visibly soiled, and as needed. Oxygen tubing, mask and nebulizer devices will be bagged and labeled with date and initials. The changing of the tubing and bagging is to prevent the spread of infection. Documentation of changes of tubing will be in the residents MAR or TAR. Licensed nursing staff will obtain physician order for any resident receiving oxygen therapy and/or nebulizer treatments to change the tubing once a week and as needed. Tubing will be changed by licensed staff on the designated day of the week and shift per the physician's order. The tubing will be dated at the time of the change. Any tubing that is not in use at the time of the tubing change will be placed in a bag for storage in the resident's room. Nasal cannulas, masks, and nebulizer mouth pieces will not be left uncovered when not in use.

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 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Laurel Woods	451 North High Street East Haven, CT 06512

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47457 Based on review of facility documentation, facility policy, and interviews for 1 of 2 certified nurse aide personnel files reviewed, the facility failed to complete annual employee performance reviews. The findings include: Review of NA #2's personnel file identified she was hired on 9/1/21, and no performance review was completed for the year of 2023. Interview with the DNS on 3/14/24 at 8:28 AM identified that certified nurse aide performance reviews are expected to be completed annually. The DNS further identified that she had begun her employment at the facility in July of 2023 and had identified that there were employee performance reviews that had not been completed in years. The DNS indicated that she has developed a plan to complete all the outstanding 2023 certified nurse aide performance reviews, with the assistance of a nursing supervisor. The DNS further indicated that once she has completed all the 2023 reviews, she will devise a calendar that will aid her in scheduling and completing annual performance reviews based on the employee's date of hire, for the year ahead. The Performance and Review policy directs the facility to provide a formal and documented performance review at the end of an employee's introductory period and will endeavor to give reviews at least annually thereafter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of facility documentation, facility policy, and interviews for 6 of 6 medication carts, the facility failed to ensure shift to shift controlled drug counts were consistently completed. The findings include: Observations on 3/11/24 between 2:50 PM - 3:26 PM of the medication carts with the Administrator identified the March 2024 narcotic count sheet (the narcotic count that the on-coming and off-going nurses complete to ensure the narcotic medications are counted) were missing signatures on multiple dates on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift on the following units: The [NAME] Terrace unit on the A side was missing 8 signatures. The [NAME] Terrace unit on the B side was missing 10 signatures. The Rosewood unit on the A side was missing 15 signatures. The Rosewood unit on the B side was missing 25 signatures. The Ashwood Court unit on the A side was missing 5 signatures. The Ashwood Court unit on the B side was missing 9 signatures. Interview with LPN #6 on 3/11/24 at 2:50 PM identified she has been employed by the facility for approximately [AGE] years. LPN #6 indicated it was the responsibility of all the nurses to sign the narcotic count sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. Interview with the Administrator on 3/11/26 at 3:26 PM identified she was not aware of the missing narcotic count signatures until now during rounds with surveyor. The Administrator indicated the expectation is that the nurses will count the narcotics at change of shift and sign the narcotic count sheet after completing the count. Interview with the DNS on 3/12/24 at 9:25 AM identified she has been with the facility since July 2023. The DNS indicated she was aware of the issue last year when she started at the facility. The DNS indicated she had created the Verification: Access to and Administration of Controlled Substances form to educate the license staff regarding counting and signing the controlled substance (narcotic count sheet) sheet. The DNS indicated the expectation of the facility is that the on-coming and out-going nurse count the controlled substances during each shift change and sign the narcotic count sheet after completing the count. Review of the Verification: Access to and administration of controlled substances identified to document nursing confirmation that she/he will adhere to all required processes in place to assure that controlled substances are handled safely. It is mandatory for all Registered Nurse's (RN'S) and Licensed Practical Nurse's (LPN'S) to sign who have access to and administer any controlled substances while employed at facility. Whenever a licensed nurse signs a controlled substance count, it means that the licensed nurse has visualized and accurately counted every substance that is in the medication cart and refrigerator. (continued on next page)

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 03/14/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the pharmacy inventory control of controlled substances identified facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a Controlled Substance Count Verification/Shift Count Sheet. The facility should: Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet. The facility should ensure that facility staff count all Schedule III-V controlled substances in accordance with facility policy and applicable law.

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 03/14/2024
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of clinical record, review of policy, and interviews for two of five residents reviewed for unnecessary medications (Resident #10, and Resident #74), the facility failed to document and monitor specific behaviors with the use of antipsychotic medication. The findings include: 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia, major depressive disorder, anxiety disorder, and sleep disorder. The quarterly MDS assessment dated [DATE] identified Resident #10 had moderately impaired cognition, identified no behaviors, and required total dependent with personal hygiene. The care plan dated 1/29/24 identified Resident #10 was at risk for an alteration in mood and behaviors, I have multiple psych diagnoses. Interventions included provide medication as prescribed by physician. Be aware of changes in my mood/behavior and notify the physician. Psych evaluation and follow up as ordered and needed. The care plan dated 1/29/24 identified Resident #10 was at risk for changes in mood state due to diagnoses of anxiety, depression, and schizoaffective disorder. Interventions include follow up with psych as needed. Be aware of and report any changes in my mental status. The care plan dated 1/29/24 identified Resident #10 was at risk for potential adverse effects of psychotropic drug use. Diagnoses mental disorder, anxiety, depression, schizoaffective disorder, and paranoid schizophrenia. Interventions included being aware of my mood state and behavior. Be aware of my interaction with residents or others for appropriateness. The physician's order dated 2/1/24 directed to administer Zyprexa (antipsychotic medication) 10 mg in the evening for anxiety as part of 25 mg dose. Zyprexa 15 mg in the evening for anxiety as part of 25 mg dose. Review of the Medication Administration Record (MAR) dated 2/1/24 - 2/29/24 failed to reflect documentation for specific behavior monitoring for the use of an antipsychotic medication Zyprexa. Review of the clinical record and the MAR dated 2/1/24 through 2/29/24 failed to reflect documentation for specific behavior monitoring for Resident #10, who was receiving Zyprexa (antipsychotic medication). The physician's order dated 3/1/24 directed to administer Zyprexa (antipsychotic medication) 10 mg in the evening for anxiety as part of 25 mg dose. Zyprexa 15 mg in the evening for anxiety as part of 25 mg dose. Review of the Medication Administration Record (MAR) dated 3/1/24 - 3/14/24 failed to reflect documentation for specific behavior monitoring for the use of an antipsychotic medication Zyprexa. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record and the MAR dated 3/1/24 through 3/14/24 failed to reflect documentation for specific behavior monitoring for Resident #10, who was receiving Zyprexa (antipsychotic medication). Interview and review of the clinical record with the DNS on 3/14/24 at 10:35 AM identified she has been employed by the facility since July 2023. The DNS indicated she was not aware of Resident #10's behavior was not being monitored daily. The DNS indicated the facility expectation was that specific behavior monitor flow sheets should have been initiated whenever a resident is receiving an antipsychotic medication. The DNS indicated the resident behavior should have been monitored and documented on every shift. Review of the facility behavior monitoring/antipsychotic medications policy identified to ensure antipsychotic medications are administered and monitored per OBRA guidelines. Residents receiving antipsychotic medications will have specific target behaviors identified and monitored every shift. Any time a resident is started on an antipsychotic medication. A behavior flow sheet will be initiated. The target behavior(s) will be recorded were indicated on the flow sheet. Each shift will record, where indicated, the number of episodes for each behavior, interventions, outcomes, and side effects. 2. Resident #74 was admitted to the facility on [DATE] with diagnoses which included vascular dementia with behavioral disturbance, vascular dementia with mood disturbance, psychotic disturbance, and anxiety. The care plan dated 10/23/23 identified Resident #74 tends to wander around the unit looking for his/her sister, granddaughter, daughter, and keys at times. Interventions included to offer emotional support as needed. Wander guard continues. The care plan dated 12/29/23 identified Resident #74 was at risk for an altercation in my mood and behaviors as evidence by wandering in and out of rooms at times. Interventions included being aware of changes in my mood and behaviors and notify the physician. Remove me to a quiet area as possible. Adjust medication as ordered. Redirect when entering another resident's room. Wander guard continues. The care plan dated 1/10/24 identified Resident #74 has a history of aggressive behavior with other residents (last occurrence 1/10/24). Interventions included psych consults as ordered. Body audit/skin check as ordered. The physician's order dated 1/11/24 directed to administer Seroquel (antipsychotic medication) 5 mg every day at lunch for dementia, delusions, and combativeness. Seroquel 10 mg every day at hours of sleep for dementia, delusions, and combativeness. Review of the MAR dated 1/1/24 - 1/31/24 identified an order with a start date on 1/14/24 to monitor, observe, and document resident behaviors every 1 hour times 48 hours. Every hour observation for 2 days. The MAR failed to reflect documentation of Resident #74 behaviors every one hour on 1/15/24 - 1/16/24 at 4:00 AM. Who utilizes an antipsychotic medication. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 1/2/24 - 1/27/24 failed to reflect documentation of Resident #74 behaviors on 1/15/24 on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift. And on 1/16/24 on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift (3:00 AM). Review of the clinical record and the MAR for the month of January 2024 failed to reflect documentation of resident behaviors every hour on 1/14/24 on the 7:00 AM - 3:00 PM shift and the 3:00 PM - 11:00 PM shift. 1/15/24 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift. And on 1/16/24 on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift (3:00 AM). Who utilizes an antipsychotic medication. The psych APRN note dated 1/10/24 identified she was asked to see Resident #74 after an incident with a peer. Behavior of concern resistant, wandering, intrusive, and compulsive. Resident #74 is not currently a danger to self or others. Current risk factors physical aggression. Per staff report Resident #74 was confused, wandering, and entered peer's room. Met with Resident #74 via telehealth, Resident #74 was guarded but cooperative with interview process. Denies mood concerns, and anxiety. Appears to be stable, no sign and symptoms of agitation. Denies wanting to harm self or others. Staff report that Resident #74 is redirectable and benefits from as needed (PRN) medication. Does not feel that medication changes are necessary at this time. Continue to provide support and reassurance. Discontinue 1:1. Psych will continue to follow. The significant change MDS assessment dated [DATE] identified Resident #74 had severely impaired cognition, exhibited wandering behavior, and was independent with bed mobility and transfer. Review of the summary report dated 1/14/24 at 1:26 PM identified on 1/10/24 Resident #74 wandered and startled Resident #76 who was sleeping in his/her room. On this occasion Resident #74 was having delusions that he/she was looking for his/her keys and believed that Resident #76 had them despite Resident #76 stating a number of times that he/she did not have the keys. Resident #74 then struck Resident #76. Resident #74 is experiencing delusions that are new and required psych evaluation of these behaviors and review of current medications. Upon completion of this investigation medications were adjusted and a new medication for delusions and agitation was added. On 1/11/24 Resident #74 medications were adjusted Trazodone dosing was changed, and Seroquel was added to address the delusions and agitation. Resident #74 behaviors were currently being observed every hour for the next 48-hours to assure the medications started are working to address the behaviors. The physician's order dated 2/1/24 directed to administer Seroquel (antipsychotic medication) 25 mg at bedtime for dementia. Review of the clinical record identified Resident #74 was hospitalized on [DATE] for complaining of chest pain and was readmitted to the facility on [DATE] with diagnoses of coronary artery disease (CAD). The physician's order dated 2/8/24 - 2/29/24 directed to administer Seroquel (antipsychotic medication) 25 mg at bedtime for dementia. Review of the MAR dated 2/1/24 - 2/29/24 failed to reflect documentation of Resident #74 behaviors every shift who utilizes an antipsychotic medication. (continued on next page)

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	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record dated 2/8/24 - 2/29/24 failed to reflect consistent documentation of Resident #74 behaviors who has a diagnoses of vascular dementia with behavioral disturbance, vascular dementia with mood disturbance, psychotic disturbance, and anxiety who utilize an antipsychotic medication. The psych APRN note dated 2/16/24 identified asked to see Resident #74 for concerns of increased yelling out, restlessness. Resident #74 has behaviors of concerns of physically assaultive, resistant, pacing, intrusive, combative, suspicious, wandering, compulsive, and delusions. Resident #74 is not currently a danger to self or others. Resident #74 appears calm at baseline, though Resident #74 does have increasing anxiety in the afternoon and evening. Discussed with medical APRN, per report Seroquel had been inadvertently stopped in the hospital and was recently restarted. Would recommend continue use of Trazodone for anxiety and irritability as well as redirection and reassurance. Continue to provide least stimulating environment. If symptoms persist would recommend increase in Seroquel with agreement from resident representative. No new orders with this visit. The physician's order dated 3/1/24 directed to administer Seroquel (antipsychotic medication) 25 mg at bedtime for dementia. Review of the MAR dated 3/1/24 - 3/8/24 failed to reflect documentation of Resident #74 behaviors every shift who utilizes an antipsychotic medication. On 3/8/24 on the 7:00 AM - 3:00 PM shift and the 3:00 PM - 11:00 PM shift failed to reflect documentation of Resident #74 behavior. The physician's order dated 3/8/24 directed for psychotropic medication: Behaviors - monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document N if monitored and none of the above observed. Document Y if monitored and any of the above was observed, select chart code. See nurse's notes and progress note findings every shift. Interview with MD #1 on 3/13/24 at 11:10 AM identified he was not aware of the issues. MD #1 indicated the facility staff should have been following the facility policy on behavior monitoring and the facility policy on behavior monitoring with antipsychotic medications. Interview and review of the clinical record with the DNS on 3/14/24 at 10:35 AM identified she has been employed by the facility since July 2023. The DNS indicated she was not aware of Resident #74's behavior was not being monitored daily. The DNS indicated the facility expectation was that specific behavior monitor flow sheets should have been initiated whenever a resident is receiving an antipsychotic medication. The DNS indicated the resident behavior should have been monitored and documented on every shift. The DNS indicated all license nurses will be in-service. Review of the facility behavior monitoring/antipsychotic medications policy identified to ensure antipsychotic medications are administered and monitored per OBRA guidelines. Residents receiving antipsychotic medications will have specific target behaviors identified and monitored every shift. Any time a resident is started on an antipsychotic medication. A behavior flow sheet will be initiated. The target behavior(s) will be recorded were indicated on the flow sheet. Each shift will record, where indicated, the number of episodes for each behavior, interventions, outcomes, and side effects.

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	075389	A. Building B. Wing	03/14/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42117 Based on observation, facility documentation, facility policy, and interviews reviewed for Dietary Services , the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The findings include: 1. A tour of the Kitchen on 3/7/24 at 9:10 AM with Cook #1 identified in the walk in refrigerator; 4 pancakes in a zip lock bag not labeled or dated, 2 large rectangle deep metal pans on 3/4 full of salad mix and one almost empty salad mix neither was not labeled or dated, a large rectangle deep metal pan a third full with scoop marks out of the puree pancake mix not labeled but dated 2/29, a large rectangle deep metal pan with puree eggs not labeled but dated 3/3, a square deep metal pan half full with a brown liquid appeared jelly thickness not labeled or dated, 3 large plastic containers with green lids with dices fruit were not labeled or dated, 15 chocolate chip cookies in a plastic bag were not labeled or dated, and a pie with tin foil over the top with some missing was not labeled or dated. Interview with the Cook #1 on 3/7/24 at 9:25 AM indicated that all foods that had been prepared must be labeled and dated and were good for 3 days. Cook #1 indicated it was all dietary staff responsibility to discard outdated foods after 3 days in the refrigerator. Cook #1 indicated she would discard all food that was not labeled, dated, and discard the outdated items. 2. Observation on 3/7/24 at 10:40 AM the Cook #1 was preparing food items on the counter in a pan and after she wiped her counter down utilizing the liquid in the small red bucket #1 with a cloth inside. Observation on 3/7/24 at 10:55 AM two dietary assistants were making sandwiches at the prep table. When they were completed making the sandwiches, they wiped the countertop down using the cloth from red bucket #2. Observation and interview with Director of Dietary #2 on 3/7/24 at 11:05 AM indicated DA #1 had just finished washing the breakfast pots and pans. Director of Dietary #2 indicated that the sanitary water was very hot to touch as she placed the testing strip in the water. Dietary Director #2 placed the testing strip in the sanitizing water (of the 3-bay sink) and it read 0-100 ppm's. Director of Dietary #2 indicated the ppm's were supposed to be between 400-600 ppm's since Covid but it used to be between 200-400 ppm's before Covid but because of Covid they increased the ppm limits. The Director of Dietary #2 indicated maybe the water was too hot and that was why the reading was low. Dietary Director #2 waited a few minutes and retried with a new test strip. Director of Dietary #2 indicated it read the same between 0-100 ppm's. Director of Dietary #2 tested red bucket #1 and indicated the strip read 0-100 ppm's. Director of Dietary #2 tested red bucket #2 and indicated the strip read 0-100 ppm's. Director of Dietary #2 indicated she would drain the sanitary sink and refill it. The Director of Dietary #2 noted while refilling the sanitary basin of the sink that the chemical from the container through the tube to the sink was not flowing. Director of Dietary #2 moved the tubing and it started to flow and stopped before the sink was filled to the fill line. Director of dietary indicated she would contact the vendor immediately to come and repair sanitizing line to the sink. (continued on next page)

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 03/14/2024
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with DA #1 on 3/7/24 at 11:20 AM indicated he had just finished washing the pots and pans from preparing breakfast and the current pots and pans were from the preparing of lunch. DA #1 indicated he had tested the water earlier this morning and it read 200 ppm' s'. DA #1 indicated they have had to have the vendor out many times to repair the line from the sanitizing chemical container to the sanitizing sink. A review of the Service Report dated 3/7/24 at 2:23 PM identified work request sanitizer not working. Metering tip was clogged, and repair man replaced the metering tip and is now testing at 200 ppm. Ultimate Sanitizer directions for eating establishments indicated scrape and pre-wash, non-porous utensils, and glasses whenever possible. Wash with a good detergent then rinse. Sanitize in a solution of at least 1 minute or for contact time specified by governing sanitary code. Water and sanitizer should test between 150-400 ppm active Quat. Change water daily or when visibly soiled. Although requested a policy for prepared foods in the kitchen it was not provided.

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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** 46040 Based on observations, clinical record review, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #48) reviewed for accidents, the facility failed to ensure clinical record reflected complete and accurate documentation related to neurological checks and RN assessments following unwitnessed falls. The findings include: Resident # 48 was admitted to the facility on [DATE] with diagnoses included dementia, repeated falls, and psychophysical visual disturbances. A nursing note dated 9/2/23 at 9:11 PM completed by RN #10 identified Resident #48 had no change in condition. The note further identified that Resident #48 was admitted to the facility on [DATE] at 2:55 PM and fell at 3:15PM onto his /her buttocks his/her buttocks but did not hit his/her head, was confused at baseline, and was unable to follow simple commands, and was oriented to his/her room prior to the fall. A nursing note dated 9/2/23 at 9:51 PM completed by RN #10 identified that Resident #48 was admitted to the facility on [DATE] at 2:55 PM and fell earlier 3:15PM. The note further identified that Resident #48 fell on his/her buttocks and hit his/her head, was confused at baseline, and was unable to follow simple commands. The note identified Resident #48 was sent to the hospital for evaluation. Review of the clinical record failed to identify additional documentation related to Resident #48 and the fall documentation on 9/2/23 related to initiation of neurological checks or vital sign monitoring. The care plan dated 9/4/23 identified Resident # 48 had a history of falls due to multiple risk factors. Interventions included offering toileting and incontinent care during first rounds on the 3PM- 11PM shift. Review of the clinical record identified Resident #48 had 2 unwitnessed falls on 9/8/23. The clinical record failed to identify any documentation on 9/8/23 related to initiation of neurological checks or vital sign monitoring following these falls. The admission MDS assessment dated [DATE] identified Resident # 48 had severely impaired cognition, was frequently incontinent of bowel and bladder and required the assistance of one to two staff members with transfers, toileting, and dressing. The MDS also identified Resident #48 had 2 or more falls with injury since admission to the facility. Review of the clinical record identified Resident #48 had an unwitnessed fall on 9/11/23 and required transport to the hospital for evaluation. The clinical record failed to identify any documentation related to initiation of neurological checks or the time Resident #48 was sent to the hospital for evaluation. The clinical record also identified Resident #48 was hospitalized from 9/11-9/15/23. (continued on next page)

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 03/14/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Laurel Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 451 North High Street East Haven, CT 06512	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified that Resident #48 had an unwitnessed fall on 9/22/23. Further review failed to identify any documentation related to initiation of neurological checks or the time Resident #48 was sent to the hospital for evaluation of the unwitnessed fall on 9/22/23. Following a request on 3/12/24 for accident/incident(A&I) reports for Resident #48 related to falls, the facility a total of 6 reports for the following dates and times: 9/2/23 3:15 PM 9/2/23 7:30 PM 9/8/23 2:30 PM 9/8/23 10:00 PM 9/11/23 3:30 PM 9/22/23 6:30 PM Review of the A&I reports also identified Resident #48 had 2 falls on 9/2/23, the first occurred at 3:15 PM and a second fall at 7:30 PM that required transport to the hospital for evaluation. The A& I reports also identified documentation related to vital sign monitoring and neurological checks initiated following each fall were attached to each A&I report and not identified within Resident #48's electronic or paper clinical records. Review of the clinical record and interview on 3/13/23 at 2:15 PM with the DNS identified there had been concerns related to RN #10's clinical documentation and she was aware of the issue. The DNS also identified that the documentation in the clinical record related to the nursing assessments and falls on 9/2/23 appeared to be duplicate documentation of the fall that occurred at 3:15 PM. The DNS identified that 2 comprehensive RN assessments should have been completed following Resident #48's falls 9/2/23 with clear documentation related to the time of each fall. The DNS also identified that updated vital signs should be obtained with a nursing assessment, and that neurological checks should be completed per facility policy, regardless of whether a resident is sent to the hospital for evaluation. The DNS identified that neurological checks should have been completed every 15 minutes for the first hour, then every hour for 4 hours, every 4 hours for 24 hours and every shift until the 72 hours was reached. The DNS identified that the nursing staff may have been confused on when Resident #48 needed to have neurological checks done, since there were multiple falls within the same day at times, but the policy would be to restart neurological checks with each new unwitnessed fall or fall with head injury. The DNS also identified the facility utilized neurological check flowsheets on paper, but these should be scanned into the resident's electronic medical record, and that vital signs for should be documented in the electronic record. Although attempted, an interview with RN #10 was not obtained. The facility policy on falls directed that residents who experience an unwitnessed fall and were unable to accurately verbalize if he/she hit their head due to cognitive status, or if there was any type of head injury, would have neurological checks instituted. The policy also directed that after a resident fall, a RN assessment would be completed. (continued on next page)

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	075389	A. Building B. Wing	03/14/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on nursing documentation directed the purpose of the policy was to capture any changes in condition that required a licensed staff assessment of a resident and should provide an account of any changes in condition, current assessments, and any concerns that could alter the resident's current plan of care. The policy further directed that nursing documentation may be in the form of a handwritten note or entered electronically and would be stored in the resident's medical record and nursing documentation should be clear, concise, and specific.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 resident (Resident #16) reviewed for Hospice, the facility failed to have compete medical record with the hospice election form and the physician certification of terminal illness specific to Resident #16. The findings include: Resident #16 was admitted to the facility with diagnoses which included Alzheimer's disease and dementia. The care plan dated 7/24/23 identified Resident #16 was receiving hospice care. Interventions included to provide emotional support to the resident and family. The significant change of condition MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, was frequently incontinent of bladder and always incontinent of bowel and required extensive assistance with bed mobility, toileting, and personal hygiene. Additionally, needed limited assistance with transfers, dressing, and locomotion on and off the unit and was receiving Hospice services. Interview with the DNS on 03/14/24 11:18 AM indicated nursing was responsible to obtain the physicians order but Social Services is responsible for the contracts and signing a resident up for a Hospice service. Interview with Business Office staff #1 on 3/14/24 at 11:20 AM indicated she had emailed the hospice agency requesting the hospice election form and the physician certification of terminal illness form. Business Office #1 indicated she was waiting for a response. Business Office #1 did provide the hospice list of contacts, a consult form stating Resident #16 was evaluated and accepted by hospice agency, a billing notification form, and an interim plan of care. Interview with the Business Office staff #1 on 3/14/24 at 11:35 AM indicated she only receives a change in billing notification form from Hospice. Business Office staff #1 indicated she does not have anything on file regarding Hospice services contract or hospice certification for Resident #16. After review of Resident #16's file in the business office, Business Office staff #1 indicated she did not have a copy of the Hospice contract signed by the resident representative or the physician terminal illness certification for Hospice. Business office #1 indicated she would contact Resident #16's hospice agency for a copy of the documents. Interview with the SW #2 on 3/14/24 at 11:40 AM indicated that Hospice does not give her any copies of the Hospice contract signed by the resident or resident representative nor does she get any copies of the Hospice physician terminal illness certification forms. SW #2 indicated she had asked the hospice company in the past but never received any documents. Interview with Business Office #1 on 3/14/24 at 1:20 PM indicated she had received the consent and election of Hospice benefit form signed by the resident representative. Business Office #1 provided a copy of the forms date and time of 3/14/24 at 12:18 PM. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Hospice Contract with the facility not dated identified each clinical record shall be completely, promptly, and accurately document all services provided to, and events concerning, each hospice resident, including evaluations, treatments, progress notes, authorizations to admissions to Hospice, physician orders entered pursuant authorizations to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party. Although requested, a facility policy for required documentation from hospice services was not provided.