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 01/29/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record and facility policy, for 3 of 3 sampled residents (Resident #8, Resident #24, and Resident #55) reviewed for pressure ulcers, for Resident #8 and Resident #24, the facility failed to wear appropriate Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) high contact care activities, and for Resident #8 and Resident #55, failed to perform appropriate hand hygiene according to infection control practices for Enhanced Barrier Precautions (EBP). The findings include: 1. Resident #8's diagnoses included cellulitis of buttock, obesity, chronic congestive heart failure, atherosclerosis of extremities, and hypertension. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #8 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, required setup or clean-up assistance with eating, and substantial/maximal assistance with toileting and personal hygiene. The Resident Care Plan in effect from 12/30/25 through 1/27/26 identified Resident #8 was on EBP in addition to the facility's standard precautions because of a higher risk of infection. Interventions included placement of an EBP sign outside the resident's room, clean hands, place on a gown and gloves, and clean hands again. a. A physician order in effect from 12/30/25 through 1/27/26 directed to follow EBP for an open wound to the buttock for infection control purposes. Interview and observation of Nursing Assistant (NA) #4 on 1/27/26 at 1:25 PM identified her entering Resident #8's room to perform personal care, wearing gloves, without the benefit of placing on a gown. NA #4 identified an EPB sign located outside of the room, indicated she needed to place on a gown prior to entering, but failed to do so as she forgot, adding Resident #8 was not assigned to her and she was just trying to help. b. A physician's order dated 1/8/26 directed to apply Gentamicin Sulfate External Ointment 0.1% to the right buttock wound topically every day and evening shift for wound care. Cleanse prior with wound cleanser, followed by Calcium Alginate, followed by a dry clean dressing. Interview and observation of Licensed Practical Nurse (LPN) #10 on 1/29/26 at 11:22 AM identified her entering Resident #8's room to perform wound care. Although an EBP sign was present outside Resident #8's door, LPN #10 failed to cleanse her hands, and failed to place on gloves and a gown prior to entering. Observation during wound care identified LPN #10 placed on gloves without cleansing her hands, removed the resident's old dressing removed her gloves and placed on a new pair of gloves without the benefit of cleansing or sanitizing her hands. LPN #10 verbalized she knew (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 01/29/2026
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was on EBP but forgot to follow the facility's EBP policy as she didn't notice the residents EBP sign outside of his/her door. LPN #10 stated she forgot to cleanse her hands in between taking off the dirty gloves and placing on the clean gloves prior to placing the clean dressing but should have. Interview with Regional Registered Nurse (RN) #3 at 11:37 AM identified that LPN #10 should have performed hand hygiene and applied appropriate PPE, which included gloves and a gown prior to providing wound care to Resident #8. RN #3 identified she was going to speak with Registered Nurse (RN) #4 to attempt to implement improvements and increase adherence to the facility's EBP policy. 2. Resident #24's diagnoses included Pressure Ulcer (PU) of the Sacral Region, Stage 4. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Resident #24 required maximum assistance for eating, toileting hygiene, shower/bathe self, transferring, and upper and lower body dressing. The Resident Care Plan in effect from 1/2/26 through 1/22/26 identified EBP in use. Interventions included hanging an EBP sign outside of the room, providers must wear a gown and gloves for the following high-contact resident care activities: dressing, bathing showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and everyone must clean their hands including before entering and when leaving the room. A physician's order in effect from 1/2/26 through 1/22/26 directed the facility to use EBP due to the presence of a wound every shift for infection control purposes. Observation on 1/22/26 at 10:09 AM outside of Resident #24's room identified an EBP sign directing PPE be worn during high-contact activities which included toileting. Nurse Aid (NA) #2 entered Resident #24's room carrying washcloths, towels, and bed linens but failed to apply PPE prior to entering. NA #2 was observed to leave the room indicating that she had changed Resident #24 due to bowel incontinence. Interview of NA #2 on 1/22/26 at 10:40 AM identified that NA #2 had not worn appropriate PPE while performing Resident #24's incontinent care stating, No I didn't wear a gown to change Resident #24; I only used gloves. NA #2 indicated she was aware of the sign and should have used a gown when performing Resident #24's incontinent care. 3. Resident #55's diagnoses included multiple sclerosis, abnormal posture and nonspecific skin eruption. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment, was dependent on staff for eating, dressing and transfers, was at risk for developing pressure ulcers, and had moisture associated skin damage. The Resident Care Plan dated 12/22/25 identified Resident #55 was at risk for an alteration in skin integrity related to decreased mobility from multiple sclerosis, and incontinence of bowel and bladder. Interventions included providing wound care as ordered and monitoring skin for signs and symptoms of breakdown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 1/8/26 directed to cleanse Resident #55's bilateral buttocks with normal saline, followed by bacitracin, followed by Calcium Alginate covered by a dry clean dressing twice a day and as needed for wound care. Observation of the Enhanced Barrier Precaution sign posted outside Resident #55's room instructed that everyone must clean their hands including before entering and when leaving the room. Observation and interview with Licensed Practical Nurse (LPN) #5 on 1/27/26 at 10:54 AM identified she placed on a gown but failed to perform hand hygiene following the gown placement. LPN #5 entered the room with wound care supplies in hand, then applied gloves without the benefit of cleansing prior to glove application. After removing Resident #55's dirty wound dressing and placing it in the trash receptacle, she continued to perform the treatment without the benefit of removing the soiled gloves, cleansing her hands, or applying clean gloves. LPN #5 identified that hand hygiene should have been performed before entering, after care, and after exiting Resident #55's room. Although LPN #5 identified she received hand hygiene education she could not identify why she did not perform hand hygiene or why she did not change her gloves when going from the dirty dressing to placing a clean dressing during wound care. Interview with Registered Regional Nurse (RN) #3 on 1/29/26 at 11:22 AM identified that hand hygiene should be performed prior to application of personal protective equipment, per the Enhanced Barrier Protection (EBP) policy. Review of the Enhanced Barrier Precautions Policy revised May 2024 directed in part that staff will perform hand hygiene and apply personal protective equipment prior to providing high contact care (which included wound care). Review of the Handwashing Policy revised November 2017 directed in part that staff will wash hands after removing gloves and after contact with wound dressings. Review of the Treatment Process policy directed in part to perform hand hygiene, apply clean gloves, remove and dispose of the dressing, remove gloves, perform hand hygiene then apply clean gloves. The Enhanced Barrier Precautions Policy effective 4/1/24, last revised 5/5/24 directed in part, that the facility will implement EBP during high-contact resident care activities for any resident with an indwelling medical device (e.g. central lines, urinary catheters, feeding tubes, and tracheostomies) or chronic wounds (e.g. pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers), regardless of MDRO (Multi-Drug Resistant Organisms) colonization or infection status. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include dressing, bathing/showering/providing hygiene, transferring (with the exception to transfers in common areas), changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.), and wound care. Appropriate signage for EBP will be visible. Appropriate PPE and hand sanitizer will be readily accessible for use. Staff will perform hand hygiene and don (place) PPE before providing high-contact care to the resident. Staff will doff (take off) PPE, perform hand hygiene after providing high-contact care to the resident and place PPE in a trash receptacle located in resident's room.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, review of documentation, and facility policy for 1 of 3 sampled residents, (Resident #19) reviewed for abuse, the facility failed to report bruises of unknown origin to the State Agency (SA). The findings include:Resident #19's diagnoses included hyperlipidemia, unspecified sequelae of cerebral infarction, and Post-Traumatic Stress Disorder (PTSD).The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment, was dependent on staff for toileting and shower/bathing self and required substantial/maximal assistance for transfers. The Resident Care Plan (RCP) dated 9/13/24 identified Resident #19 was at risk for falls related to impaired balance. Interventions included staff to put the call bell within reach when the resident was in bed or bedside chair, to receive Physical Therapy (PT)/Occupational Therapy (OT) as ordered, and for staff to offer assistance with toileting at bedtime. A nursing note dated 10/7/24 at 9:32 PM and investigation identified that Resident #19 was observed with a purple-colored bruise to his/her left flank (area between the ribs and hip). Resident #19 was unable to identify how the bruises occurred and the investigation did not conclusively identify the cause other than the resident was known to lean to the left.A nursing note dated 1/14/25 at 1:44 AM and investigation identified that Resident #19 was observed with 2 bruises to his/her upper posterior right arm. Resident #19 was unable to identify how the bruises occurred and the investigation did not identify a cause. Review of the state agency's incident reporting system failed to identify the observations of bruises of unknown origin on 10/7/24 and 1/14/25 were reported.Interview with the Director of Nurses (DNS) and Assistant Director of Nurses (ADNS) on 1/28/26 at 2:41 PM identified that the DNS and ADNS were responsible for reporting incidents to the State Agency (SA). Additionally, the DNS indicated that she thought she did not have to report the incidents to the SA unless the facility substantiated abuse from their investigation. The DNS and ADNS indicated that they would report all bruises of unknown origin to the SA in the future.Review of the undated abuse policy directed, in part, staff must identify and report any suspicious bruising, patterns of injury, or behavioral changes that may indicate abuse. The DNS or designee will notify the residents family, physician, Department of Public Health (DPH), and local police as needed. A follow-up report, including conclusions and any actions taken, will be submitted online to DPH within five (5) days of the alleged incident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 2 of 3 sampled residents (Resident #45 and Resident #64) reviewed for Activities of Daily Living (ADL), the facility failed to provide hygiene assistance for staff dependent care. The findings include:1. Resident # 45?s diagnoses included diabetes with diabetic neuropathy (nerve damage), muscle weakness and dysphagia (swallowing difficulty).The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 had a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment, and was totally dependent on staff with eating, hygiene, and toileting, and was always incontinent of bowel and bladder.The Resident Care Plan dated 12/30/25 identified Resident #45 required assistance with ADLs due to weakness did not get out of bed, was bed bound at home, and refused showers. Interventions included if care was refused remind the resident of the importance but honor his/her right to refuse, offer assistance as needed with washing, bathing, dressing, toileting and oral hygiene, and offer comfort bed bath if refused a bath/shower. Observation on 1/21/26 at 12:39 PM identified Resident #45's fingernails were very long.Observation on 1/27/26 at 10:05 AM identified Resident #45's fingernails were long with brown debris under the fingernails.Interview with Nurse Aid (NA) #4 on 1/27/26 at 1:59 PM identified she had not cleaned or cut Resident #45's fingernails today yet but she would.2. Resident #64's diagnosis included metabolic encephalopathy, chronic respiratory failure with hypoxia (inadequate oxygen), hemiplegia (paralysis) and hemiparesis (weakness) following cerebral vascular disease affecting the left non-dominant side.The annual Minimum Data Set assessment dated [DATE] identified Resident #64 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment and required partial moderate assistance with eating and was totally dependent on staff for hygiene, dressing, toileting, transfers, and was always incontinent of bowel and bladder.The Resident Care Plan dated 12/2/25 identified Resident #64 required ADL assistance, continence fluctuated, may refuse to be shaved and would inform staff when shaving assistance was requested; choose to stay in bed most days. Interventions included if refused assistance please remind Resident #64 of the importance of care but honor the right to refuse. Required assistance with daily washing, dressing, grooming, bathing, and mouth care.Observation on 1/21/26 at 12:24 PM identified that Resident # 64 had long fingernails and was unshaven. Resident #64 identified that s/he wanted to be shaven and was not growing a beard.Observation on 1/27/26 at 10:08 AM identified Resident #64's beard area had been trimmed but was not clean shaven. Resident #64 wanted to be clean shaven and fingernails remained long. Resident #64 was agreeable to having nails trimmed. Resident #64's shaving supplies were observed in the nightstand.Observation on 1/28/26 at 9:34 AM identified Resident #64's fingernails remained long with debris underneath.Interview, observation, and review of clinical records with LPN #8 on 1/28/26 at 10:46 for Resident #45 and Resident #64 identified that showers had been received as documented in the clinical record and failed to indicate any refusals during the month of January 2026. LPN #8 stated that the expectation for showering included washing hair, shaving, and fingernail cleaning and trimming. Observation of Resident #45 with LPN #8 identified that Resident #45's fingernails were long, with debris underneath and nail care was needed. Observation of Resident #64's fingernails identified debris underneath and that shaving hygiene assistance was needed to which Resident #64 was agreeable. LPN #8 could not explain why Resident #45 nor Resident #64's fingernails were long and unclean with a brown substance underneath or why Resident #64 was unshaven. Subsequent to surveyor inquiry, LPN #8 indicated she would direct NA #4 to provide the necessary care to both Resident #45 and Resident #64.Interview and record review with the Director of Nursing (DNS) and Assistant Director of Nursing (ADNS) on 1/28/26 at 1:52 PM identified Resident #45 and Resident #64 had showers as documented in the clinical record but could not explain why nail care and shaving had not been provided. The DNS further indicated that the expectation was to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide nail care and shaving on shower days, this care should also be provided as needed.Subsequent observations of both Resident #45 and #64 identified nail care and shaving had been provided.Attempts to interview NA #5 were unsuccessful.Review of the AM Care/ADL policy dated 12/9/14 directed, in part, nursing staff will assist with AM care for each resident daily as needed. Shave resident if needed unless otherwise indicated using regular razor or personal electric razor. Provide fingernail care including trimming nails if needed. If residents refused care, please reapproach, and notify the nurse. Document all care given as well as care refusals in POC (electronic medical record).

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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** Based on observations, interviews, and record review for 1 of 2 sampled residents (Resident #1) reviewed for accommodation of needs, and for 1 of 4 sampled residents, (Resident #5) reviewed skin conditions, the facility failed to follow physician's orders for air mattresses and additionally, for Resident #5, failed to follow a physician's order for heel offloading (elevation.) The findings include:1. Resident #1's diagnoses included dorsalgia (back pain), malignant neoplasm of skin, and unspecified severe protein calorie malnutrition. The physician's order dated 12/23/25 directed for skin prevention protocol: pressure relieving mattress to be in place every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment, was dependent on staff for dressing and toileting with substantial/maximal assistance needed for transfers. Additionally, Resident #1 had a pressure ulcer/injury, was at risk for developing pressure ulcers, and had a pressure reducing device for his/her bed. The Resident Care Plan dated 12/29/25 identified Resident #1 was at risk for alteration in skin integrity relating to a stage 3 pressure ulcer to the coccyx present on admission which resolved on 12/23/25. Interventions included an anti-pressure low air loss mattress to be in place, gentle handling during transfers and to inspect skin when providing care for signs and symptoms of skin breakdown. Review of the admission Braden Scale Assessment (risk for developing pressure ulcers) dated 12/29/25 identified Resident #1 had a Braden scale score of 16 indicating he/she was at high risk for pressure ulcer development. The physician's order dated 1/5/26 directed for a low air loss mattress, check function and setting every shift (weight 95 pounds). A review of the Medication Administration Record from 1/5/26 through 1/27/26 identified nurse initials reflecting every day, evening, and night shift checked function of the pressure relieving mattress and set to 95 pounds. Interview and observation of Resident #1 in bed on 1/21/26 at 11:08 AM identified he/she was having difficulty sleeping because the bed was broken for a week now, the mattress was sunken down to the point that he/she could feel the metal, and although he/she had informed the NA, nothing has been done. Observation of the pressure relieving mattress identified the appearance of being sunken in and the pressure was set at 325 pounds. Interview with Nurse Aid (NA) #1 on 1/21/26 at 12:49 PM identified she was Resident #1's regular NA, and that morning he/she complained about the bed and having backache due the mattress being improperly inflated. Additionally, NA #1 identified it was facility policy to notify maintenance of malfunctioning equipment by putting the issue in the maintenance book; however, she was unable to identify why she had not made anyone aware of Resident #1's report of the pressure relieving mattress malfunctioning. Interview, observation, and clinical record review with Licensed Practical Nurse (LPN) #1 on 1/21/26 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:52 AM identified it was the policy for the charge nurse to check the function and setting of the pressure alternating mattresses every shift, and if there were any issues with a mattress it should be reported to maintenance immediately. Observation of Resident #1's pressure relieving mattress with LPN #1 identified Resident #1 in bed with the mattress set to 325 pounds. LPN #1 stated she could not identify if that was the appropriate setting, but when she peeked in the room earlier it did not appear to be sinking as it was currently. Resident #1's clinical record review with LPN #1 identified that per the physician's order the pressure relieving mattress should be set to 95 pounds, however she could not identify why it was set to 325 pounds or why she signed off on the function and setting of the mattress when it was not set per physician's order and not functioning as intended. Interview with Resident #1 on 1/21/26 at 12:53 PM identified he/she felt the bone in my butt and I've been complaining with no results. I told the guys that were in here earlier, but no one listens to me. Interview with the Maintenance Director on 1/21/26 at 1:07 PM identified it was facility policy for staff to use the maintenance book or call the Maintenance Department if there was an issue with broken or malfunctioning equipment that needed to be addressed immediately. The Maintenance Director further identified that although staff did not alert him to an issue with Resident #1's bed, when he was in the room at 11:00 AM Resident #1 complained of his/her bed being too soft so he doubled the setting from 125 pounds to 325 pounds. Additionally, the Maintenances Director identified that it was the departments practice to increase the setting on a mattress when there was a complaint of a malfunctioning pressure reducing bed. Observation of Resident #1's pressure reducing mattress with the Maintenance Director identified Resident #1 in bed, with the bed set to 325 pounds and an exclamation mark alert lit up in red on the display. The Maintenance Director unplugged and re-plugged in the bed stating it did not appear the pressure relieving mattress was working since it was still soft. He indicated that he would alert the Nursing Department of the issue immediately. Subsequent to surveyor inquiry review of a nurses note dated 1/21/26 at 2:00 PM, identified that due to decreased comfort and decreased mattress inflation, Resident #1 was provided with a new mattress. Observation on 1/22/26 at 9:16 AM and 1/27/26 at 10:21 AM identified Resident #1 in bed with the pressure relieving mattress set to 160 pounds. Interview and record review with Infection Prevention Registered Nurse (RN) #4 on 1/27/26 at 1:25 PM identified that it was facility policy to provide residents with pressure relieving mattresses if they had a wound or for comfort, with physician's orders dictating the appropriate weight setting for residents with wounds. A review of Resident #1's electronic health record with RN #4 identified that per the physician's order, he/she had a pressure relieving mattress that should be monitored for function and set to 95 pounds. Additionally, RN #4 identified the expectation was only nurses (not maintenance staff) changed the setting to reflect physician's orders and any pressure alternating mattress troubleshooting should be performed with residents out of bed. 2. Resident #5's diagnoses included chronic obstructive pulmonary disease, type 2 diabetes, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Interview of Mental Status (BIMS) score of 4 indicating severe cognitive impairment and was dependent on staff for showering/bathing, personal hygiene, sit to lying in bed, lying to sitting on the side of the bed, and transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 12/29/25 identified Resident #5 was at risk for alteration in skin integrity related to decreased mobility. Interventions included inspecting skin when providing care and an anti-pressure mattress in bed. Physician's orders in effect from 1/21/26 through 1/27/26 directed to ensure Resident #5 's heels were off loaded (not touching the mattress) while in bed, placement of a Low Air Loss (LAL) mattress and to check function and setting every shift set to 207 pounds. Observation on 1/21/26 at 9:55 AM and 1/27/26 at 10:13 AM identified Resident #15 lying in bed with the head of the bed elevated, no LAL mattress was present, and his/her heels were not offloaded. Interview and observation with the Licensed Practical Nurse (LPN) #9 on 1/27/26 at 10:15 AM identified that that it was the facility's policy to provide and set a LAL mattress per the physician orders and to check daily to see if the LAL mattress was functioning properly. LPN #9 indicated that residents with physician orders of offloading heels while in bed should have either heel boots on or pillows under the ankles to relieve pressure from the heels off the mattress. LPN #9 indicated that Resident #5 had current physician orders for offloading heels while in bed and an LAL mattress to be set at 207 lbs. LPN #9 observed that Resident #5 was lying in bed without his/her heels offloaded and that there was no LAL mattress present per the physician orders. LPN #9 could not identify why Resident #5's heels were not offloaded, or why a LAL mattress was not present but indicated they should have been per the physician orders. Interview and observation with the Assistant Director of Nurses (ADNS) on 1/22/26 at 9:41 PM identified that it was the facility's policy to provide and set a LAL mattress per the physician orders. The ADNS indicated that if a resident had orders for offloading heels, their heels should have a pillow under them or some sort of barrier to relieve pressure and that it was the responsibility of the unit nurse to carry out the physician orders as directed. The ADNS identified that Resident #5 had current physician orders for offloading heels while in bed and an LAL mattress to be set at 207 lbs. The ADNS identified that Resident #5 was lying in bed without the benefit of his/her heels being offloaded and that there was no LAL mattress present per physician order. The ADNS indicated that she did not know why the physician orders were not being followed but believed that it was because the resident had a wound that healed. Additionally, the ADNS identified that per the current physician order, Resident #5 should have had a LAL mattress present, and his/her heels should have been offloaded.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review for 1 of 3 sampled residents (Resident #55) reviewed for pressure ulcers, the facility failed to ensure a pressure-reducing mattress was set per the physician's orders for a dependent resident with wounds. The findings include:Resident #55's diagnoses included multiple sclerosis, abnormal posture, and nonspecific skin eruption.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment, and was dependent on staff for eating, dressing and transfers. Additionally Resident #55 was always incontinent, was at risk for developing pressure ulcers, had moisture associated skin damage and was receiving skin and ulcer/injury treatments that included a pressure reducing device.Review of the quarterly skin evaluation dated 12/9/25 identified Resident #55 had a Braden Scale (pressure ulcers risk assessment) score of 14 indicating he/she was at high risk for pressure ulcers.The Resident Care Plan dated 12/22/25 identified Resident #55 was at risk for an alteration in skin integrity related to decreased mobility from multiple sclerosis, and incontinence of bowel and bladder. Interventions included providing wound care as ordered, monitoring skin for signs and symptoms of breakdown, and a pressure reducing mattress when in bed.A physician's order dated 1/6/26 directed for a low air loss mattress, check function each shift and set to 173 pounds.A review of the Medication Administration Record dated 1/6/26 through 1/27/26 identified nurse initials reflecting day, evening and night shift nurses had checked function, and the low air loss mattress was to be set at 173 pounds.A review of the wound care specialist progress note dated 1/22/26 at 10:45 AM identified Resident #55 was receiving treatments as recommended with the wound to the left buttock resolved and a reoccurrence of the moisture associated skin damage to the right buttock. (per wound assessment reports, Resident #55 had recurring moisture associated skin damage to bilateral buttocks since October 2025). Additionally, the progress note identified the wound measured 1.22 centimeters (CM) by 1.2 cm by 0.1 cm with a moderate amount of serosanguinous (bloody/watery) drainage. A new treatment to cleanse the wound, apply bacitracin followed by calcium alginate with silver to the base of the wound and secure with a dry clean dressing twice a day was recommended.Observations on 1/21/26 at 10:00 AM and at 1:54 PM, and on 1/22/2026 at 12:50 PM identified Resident #55 in bed with the pressure reducing mattress set to 450 pounds (205 kg), and a white sticker on top of the pump reading 200 lbs. Interview and observation with Licensed Practical Nurse (LPN) #5 on 1/27/26 at 10:54 AM identified that the pressure relieving mattresses were checked by the charge nurses, but she could not identify what Resident #55's pressure mattress should have been set to, what the white sticker indicating 200 lbs. on top of the pump referred to, or where she could find the information.Interview and record review with Infection Prevention Registered Nurse (RN) #4 on 1/27/26 at 1:25 PM identified that it was the facility policy to provide residents with pressure relieving mattresses if they had a wound or for comfort, with physician's orders dictating the appropriate weight setting for residents with wounds. Additionally, review of Resident #55's electronic health record identified that he/she had a pressure relieving mattress that should be monitored for function and should have been set to 173 pounds.Although requested, the facility failed to provide a policy on mattresses, pressure reducing devices, low air loss mattresses or pressure alternating mattresses.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review for the only sampled resident (Resident #7) reviewed for hemolytic treatments, the facility failed to follow a hemolytic treatment center directive for a fluid restriction and failed to monitor intake/output amounts. The findings include:Resident #7's diagnoses included end stage renal disease, hypertension, and peripheral vascular disease.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, was independent with eating and personal hygiene and was receiving hemolytic treatment.The Resident Care Plan dated 1/23/25 identified Resident #7 received hemolytic treatments due to chronic renal disease and was at risk for bleeding, infection, and septic shock. Interventions included fluid restriction as per the physician orders, intake and output as ordered/per policy, and to watch for signs and symptoms of fluid overload and report to the physician.The physician's order dated 1/6/26 directed a fluid restriction of 1200 milliliters (ml).A review of the physician's orders for January 2026 failed to direct intake/output monitoring.The Nutritional assessment dated [DATE] directed a fluid restriction of 1200 ml identifying it was per the hemolytic treatment registered dietician.Review of the Physician/Advanced Practice Registered Nurse (APRN) notes dated 1/6/26 through 1/28/26 failed to identify Resident #7 was on a fluid restriction, failed to address fluid restriction compliance, and failed to indicate that intake/output was being monitored.Review of nursing progress notes dated 1/6/26 through 1/28/26 failed to identify Resident #7 was on a fluid restriction, had maintained fluid restriction compliance, or that intake/output was being monitored.Review of the Nurse Aid Resident Assignment failed to identify Resident #7 was on a fluid restriction or intake/output monitoring was required.Interview and record review with Licensed Practical Nurse (LPN) #6 on 1/27/26 at 10:24 AM identified it was facility policy to follow fluid restriction and intake/output for residents per the physician's orders. Review of Resident #7's electronic health record with LPN #6 identified a physician's order for a fluid restriction of 1200 ml, however further review failed to identify that an order to monitor intake/output was in place or that intake/output monitoring had occurred or was documented. Although LPN #6 could not identify why Resident #7's intake/output was not being monitored, it should have been due to the fluid restriction orders.Interview and record review with the Director of Nurses (DNS) on 1/27/26 at 1:52 PM identified it was facility policy for intake/output to be monitored if a resident was identified as dehydrated, not eating, or was on a fluid restriction. Additionally, the facility policy for a fluid restriction required a physician's order and that nursing would monitor the resident's intake/output so that the restriction would be maintained. Review of Resident #7's electronic health record with the DNS identified he/she had a physician's order for a 1200 ml fluid restriction, which was determined by the hemolytic treatment center. The DNS failed to identify intake/output was being monitored or documented for Resident #7 but should have been. Additionally, the DNS identified the fluid restriction order was put in as a diet order instead of a monitoring order which did not trigger the intake/output to be monitored or documented.Interview with the hemolytic treatment center, Registered Dietician, on 1/28/26 at 10:41 AM identified that Resident #7 had been on a 1200 ml fluid restriction since 1/6/26, and that was communicated to the facility's Registered Dietician. Additionally, the hemolytic center Registered Dietician identified that failure in adhering to a fluid restriction could result in Resident #7 having an increased blood pressure, weight gain due to fluid retention, and there was a concern that fluid overload might lead to hospitalization.Interview and record review with APRN #1 on 1/28/26 at 11:56 AM identified it was her practice to follow recommendations from the hemolytic center and the renal physician for a plan of care for hemolytic treatment residents. APRN #1 indicated that she did not usually check on intake/output and fluid restrictions. Additionally, even though the intake/output was not being tracked she identified she was in agreement with the plan of care currently being provided because Resident #7 did not exhibit (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms of fluid overload and blood pressure fluctuations were considered normal for a hemolytic treatment resident.Review of the Hemolytic Treatment Policy directed, in part, that the facility is responsible for providing pre and post dialysis care to the resident while at the facility. Additionally, the procedure specified to maintain fluid restrictions as ordered, monitor intake/output and notify the physician and dialysis if the resident is non-compliant with fluid restrictions.Review of the Intake & Output Monitoring Policy directed in part to ensure timely identification of hydration risk and appropriate use of intake/and output monitoring as a targeted clinical intervention, based on individualized resident needs and assessment findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, review of clinical records, and facility policy for 1 of 7 sampled residents reviewed for medication administration, the facility failed to ensure that delayed release medications were not crushed resulting in a medication error rate above 5% (11.11%). The findings include:Resident #20's diagnoses included chronic obstructive pulmonary disease, dementia with psychotic disturbance and atherosclerotic heart disease.Physician's orders dated 12/15/25 directed in part, to administer Aspirin 81 mg Delayed Release (DR) tablet orally daily, Depakote 250 mg DR orally daily, and Pantoprazole 20 mg DR orally 2 times a day.Observation on 1/21/26 at 9:33 AM with LPN #1 during medication administration identified Resident #20's medications were in a plastic cup and upon administration, Resident #20 was asked if s/he would like her/his medications crushed, s/he replied yes. LPN #1 donned gloves, placed the 3 morning medications in an envelope, crushed the contents, and then placed them in applesauce and administered the medications to Resident #20. During a subsequent review of the physician's orders and interview with RN #4 on 1/21/26 at 2:00 PM indicated that delayed release medications (Aspirin DR, Depakote DR and Pantoprazole DR) should not be crushed.Review of the facility policy for Medication Administration and General Guidelines directed that if it is safe to do so, medication tablets may be crushed or capsules emptied out when the resident has difficulty swallowing; long-acting medications or enteric coated dosage forms should generally not be crushed.According to the US Food and Drug Administration, long-acting medications, extended release, delayed release, enteric coated medications should not be split, chewed or crushed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, review of the clinical record, facility policy, and interviews during a review of medication storage for 1 of 3 medication carts, for the only sampled resident (Resident #85) reviewed, the facility failed to ensure expired medications were disposed of properly and not administered after the expiration date. The findings include:Resident #85's diagnosis included osteomyelitis and type II diabetes mellitus.A physician's order dated 12/19/25 directed Insulin Lispro Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro), inject per a sliding scale, subcutaneously, 3 times a day for diabetes mellitus.Observation on 1/22/26 at 10:34 AM, of the medication cart located at the nurse's station, identified Resident #85's Lispro insulin flex pen was dated 12/19/25. Interview with LPN #4 identified that the resident's insulin was used as needed for coverage and hasn't been administered lately.Review of the January Medication Administration Record (MAR) identified that Lispro insulin was administered per the sliding scale on 1/17/26, 1/18/26, 1/19/26 and 1/20/26 at 4:30 PM and 1/19/26 at 11:30 AM for coverage of blood glucose results over 251 milligrams, 4 days after the discard date of 1/17/26.Subsequent interview with the ADNS at on 1/22/26 at 10:37 AM, identified that the resident received insulin coverage on 1/20/26 at 4:30 PM therefore, the flex pen was expired and should have been discarded after 28 days (1/16/26) per facility expectations.Review of the facility policy for Expiration of Insulin Vials directed Humalog (Lispro) insulin should be discarded when un/opened in 28 days.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 2 of 3 sampled residents (Resident #9 and Resident #19) reviewed for hospitalizations, the facility failed to provide a written notice of the right to hold a bed upon discharge from the facility for a medical leave. The findings include:1. Resident #9's diagnoses included extremity amputations, diabetes with underlying diabetic neuropathy (nerve damage), and altered mental status. The annual Minimum Data Set assessment dated [DATE] identified Resident #9 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment and required supervision with toileting and transfers, substantial maximal assistance with lower body dressing, and was independent with eating, hygiene, upper body dressing, and bed mobility. The Resident Care Plan dated 12/2/25 identified Resident #9 was re- hospitalized due to precarious medical condition, at risk for re-hospitalization. Interventions included activity as tolerated, body audit, Braden scale and medication review upon re admission, notify physician for any changes in status. A nurse's note dated 1/16/25 at 6:31 PM identified at 7:27 PM Resident #9 was having increased confusion with a blood pressure of 136/97, pulse 76, temperature 98.1, and a weight of 229 pounds. No changes in respiratory, cardiovascular or neurological status. No changes in abdominal, gastrointestinal or urinary systems, were observed. Resident #9 was post a fall day 1 and displaying increased confusion and trouble word finding and was unable to complete a sentence when assessed. The Advanced Practice Nurse Practitioner (APRN) was notified. A new order to send Resident #9 to the emergency room for evaluation was obtained and Resident #9 was transported by ambulance to the hospital at 6:00 PM. A review of social services notes from 11/2025 through 1/2026 failed to identify the responsible party/conservator was notified of the bed hold policy upon Resident #9 being sent to the hospital. The medical record failed to contain documentation that Resident #9 or the responsible party was notified of the right to hold the bed during a medical leave of absence. 2. Resident #19's diagnosis included severe protein calorie malnutrition, viral intestinal infection and hyperosmolality (concentrated blood due to dehydration or high sodium levels) and hypernatremia (high sodium levels in the blood.) The significant change Minimum Data Set assessment dated [DATE] identified Resident #19 had a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment and required substantial maximal assistance with hygiene and was totally dependent on staff for eating, bed mobility, toileting, dressing, and transfers. The Resident Care Plan dated 12/9/25 identified Resident #19 had a positive level of care with Ascend due to a psychiatric diagnosis. Interventions included a guardian/conservator for decisions regarding health and safety, a minimum of a yearly comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis and appropriate treatments. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	A Situation Background Assessment and Recommendation form dated 1/3/26 at 10:11 AM identified Resident #19 reported vomiting coffee ground emesis, that was unwitnessed. The resident's mental status was noted with increased confusion or disorientation, and Resident #19 had nausea and vomiting this morning. A report from the night Registered Nurse (RN) supervisor, identified Resident #19 had vomited coffee ground emesis this morning. Upon palpation of the resident's abdomen, he/she complained of tenderness. The RN supervisor notified the APRN on 1/3/26 at 9:16 AM and an order was received to send Resident #19 to the emergency room for further evaluation. A review of social services notes from 11/2025 through 1/2026 failed to identify the responsible party/conservator was notified of the bed hold policy upon Resident #19 being sent to the hospital. The medical record failed to contain documentation that Resident #19 or the responsible party was notified of the right to hold the bed during a medical leave of absence. Interview with Social Worker # 1 and Social Worker # 2 on 1/29/26 at 11:25 AM indicated that they do not issue the bed hold policy form to residents that go out to the hospital. Business office or Admissions staff was responsible to issue bed hold forms. Interview and clinical record review with Regional Business Office Manager on 1/29/26 at 11:30 AM identified the medical record failed to reflect documentation a bed hold policy form was delivered to Resident #9 and Resident #19 or the responsible party at the time of the hospitalization. The Regional Business Office Manager could not explain why a form was not issued and indicated that a bed hold policy form should have been sent with the resident or the responsible party contacted and documented in the clinical record of the right to hold the bed during hospitalization. Review of the bed hold policy dated 10/1/19 directed, in part, it is the policy of Apple Rehab to notify all residents of their rights to reserve their bed upon discharge to the hospital. The notice regarding reservation of the Residents' bed if the resident is hospitalized is given to each resident upon admission and this states the facility's policy regarding payment for days absent from the facility. The notice regarding reservation of the resident's bed will also be given by the social worker or the facility's designee to each resident/responsible party upon discharge to the hospital. The resident bed hold documentation form will be completed by social services or admissions for each hospitalization and maintained in the resident's financial folder. It should also be scanned into the Point Click Care (PCC) miscellaneous tab.