STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075403	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab West Haven	308 Savin Avenue West Haven, CT 06516

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who required emergency services and transfer to the hospital, the facility failed to conduct an complete and accurate assessment at the time the resident was noted to have a change in condition. The findings include: Resident #1's diagnoses included dementia, dysphagia (difficulty swallowing), and gastroesophageal reflux disease (GERD). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decision regarding tasks of daily life and was dependent on staff for all activities of daily living. The Resident Care Plan dated 1/3/25 identified Resident #1 had a potential for aspiration, asthma, and GERD. Interventions directed to assist with meals, check vital signs and lung sounds for any signs of aspiration, keep the resident in an upright position for thirty (30) minutes after meals, keep head of bed elevated, monitor for nausea, vomiting and signs of aspiration. The Situation Background Assessment Recommendation (SBAR) dated 2/9/25 at 6:42 AM identified Resident #1 was unresponsive and in respiratory distress, breathing with accessory muscles and had increased congestion. The documented assessment identified the following: blood pressure 124/78, pulse 78, respirations 18, pulse oximetry 88%, and temperature 98.3 obtained on 2/3/25 at 4:17 PM. The note identified, subsequent to physician notification, Resident #1 was transferred to the hospital. Upon further review, the clinical record failed to reflect vital signs were current and/or repeated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The prehospital care report dated 2/9/25 identified Emergency Medical Services (EMS) was dispatched to the facility at 5:30 AM. Upon entering the room, EMS found Resident #1 lying in a semi-Fowler's position with rapid gurgling respiration, Resident #1 was not alert and responsive only to pain, and Resident #1 was on two (2) liters of oxygen. The staff stated Resident #1 had vomited twice, they did not know when Resident #1 had initially vomited, the mouth was noted to be full of sputum and vomit, Resident #1 was rolled onto the left side, the airway was cleared, and lung sounds had bilateral rhonchi and mild wheezing. Resident #1's oxygen saturation was 72% on the two (2) liters, the oxygen was increased to six (6) liters with a slow increase to the 80's, the resident's airway was suctioned to remove traces of vomit, placed on non-rebreather at fifteen (15) liters and the oxygen saturation level increased to the upper 90's. The report identified Resident #1's blood pressure was 169/76, pulse 124, and respirations 40. The hospital Discharge summary dated [DATE] identified Resident #1 was admitted to the hospital on [DATE] with diagnoses that included an altered mental status, influenza A infection, a urinary tract infection, and aspiration pneumonia of both lungs due to gastric secretions. Resident #1 was treated with antibiotics and improved rapidly with return to the facility on 2/16/24. Interview with one (1) of the paramedics, Person #1, on 2/26/25 at 10:35 AM identified on 2/9/25 EMS was dispatched to the facility for a report of Resident #1 having difficulty breathing. Person #1 stated when they arrived at Resident #1's bedside, Resident #1 was choking on his/her vomit, and there were no facility staff members in the room. Person #1 identified Resident #1 was found lying in a semi-Fowler's position (on back with head of bed at a 30-40 degree angle). Person #1 stated Resident #1 had oxygen at two (2) liters on, but it appeared no other interventions were being done. Person #1 identified although a staff member indicated Resident #1 vomited two (2) times, staff did not provide any vital signs or further reports, only the written transfer paperwork including DNR status was provided. Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #2, on 2/26/25 at 12:35 PM identified RN #1, the 11PM-7AM Nursing Supervisor called her to the floor to assist in preparing Resident #1 for transfer to the hospital and that RN #1 requested she complete the hospital transfer paperwork. RN #2 stated she did a brief assessment and although she obtained Resident #1's vital signs she did not enter them into the clinical record. Interview with the Director of Nursing (DON) on 2/26/25 at 2:00 PM identified when a resident had a change in condition the expectation was to check vital signs, complete an assessment and perform appropriate interventions and then document that information in the clinical record. The DON explained, for a resident that vomited, the expectation would have been for staff to ensure the head of bed was elevated, turn the resident on his/her side, and clean the resident's mouth. Attempts to interview RN #1 and NA #3 were unsuccessful.

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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 clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who had a change in condition and required transfer to the hospital, the facility failed to monitor and implement interventions until Emergency Medical Services arrived and failed to give a thorough hand off report. The findings include: Resident #1's diagnoses included dementia, dysphagia (difficulty swallowing), and gastroesophageal reflux disease (GERD). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decision regarding tasks of daily life and was dependent on staff for all activities of daily living. The Resident Care Plan dated 1/3/25 identified Resident #1 had a potential for aspiration, asthma, and GERD. Interventions directed to assist with meals, check vital signs and lung sounds for any signs of aspiration, keep the resident in an upright position for thirty (30) minutes after meals, keep head of bed elevated, monitor for nausea, vomiting and signs of aspiration. The Situation Background Assessment Recommendation (SBAR) dated 2/9/25 at 6:42 AM identified Resident #1 was unresponsive and in respiratory distress, breathing with accessory muscles and had increased congestion. The note identified, subsequent to physician notification, Resident #1 was transferred to the hospital. The prehospital care report dated 2/9/25 identified Emergency Medical Services (EMS) was dispatched to the facility at 5:30 AM. Upon entering the room EMS found Resident #1 lying in a semi-Fowler's position with rapid gurgling respiration, Resident #1 was not alert and responsive only to pain, and Resident #1 was on two (2) liters of oxygen. The staff stated Resident #1 had vomited twice, they did not know when Resident #1 had initially vomited, the mouth was noted to be full of sputum and vomit, Resident #1 was rolled onto the left side, the airway was cleared, and lung sounds had bilateral rhonchi and mild wheezing. Resident #1's oxygen saturation was 72% on the two (2) liters, the oxygen was increased to six (6) liters with a slow increase to the 80's, the resident's airway was suctioned to remove traces of vomit, placed on non-rebreather at fifteen (15) liters and the oxygen saturation level increased to the upper 90's. Once on the stretcher Resident #1 was kept in a right recumbent position, lying on the side, the resident responsiveness improved. The report identified Resident #1's blood pressure was 169/76, pulse 124, and respirations 40. Resident #1 was transported to the hospital at 6:05 AM. The hospital Discharge summary dated [DATE] identified Resident #1 was admitted to the hospital on [DATE] with diagnoses that included an altered mental status, influenza A infection, a urinary tract infection, and aspiration pneumonia of both lungs due to gastric secretions. Resident #1 was treated with antibiotics and improved rapidly with return to the facility on 2/16/24. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with one (1) of the paramedics, Person #1, on 2/26/25 at 10:35 AM identified on 2/9/25 EMS was dispatched to the facility for a report of Resident #1 having difficulty breathing. Person #1 stated when they arrived at Resident #1's bedside, Resident #1 was choking on his/her vomit, and there were no facility staff members in the room. Person #1 identified Resident #1 was found lying in a semi-Fowler's position (on their back with the head of the bed at a 30-40 degree angle). Person #1 indicated he/she and the other EMS present heard Resident #1 gurgling, turned the resident onto a side, cleared the airway, and the resident's breathing began to improve. Person #1 stated Resident #1 had oxygen at two (2) liters on, but it appeared no other interventions were being done. Person #1 identified although a staff member indicated Resident #1 vomited two (2) times, staff did not provide any vital signs or further reports, only the written transfer paperwork including DNR status was provided. Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #2, on 2/26/25 at 12:35 PM identified the 11PM-7AM Nursing Supervisor, RN #1, called her to the floor to assist in preparing Resident #1 for transfer to the hospital. RN #2 identified she conducted a brief assessment. Interview with the Director of Nursing (DON) on 2/26/25 at 2:00 PM identified when a resident had a change in condition the expectation was to check vital signs, complete an assessment and perform appropriate interventions and then document that information in the clinical record. The DON explained, for a resident that vomited, the expectation would have been for staff to ensure the head of bed was elevated, turn the resident on his/her side, and clean the resident's mouth. The DON stated when a resident had a change in condition and EMS was called the expectation was that a licensed staff member would remain with the resident until EMS arrived and then provide report to EMS. Attempts to interview RN #1 and NA #3 were unsuccessful.