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	08/20/2025

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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on clinical record review and staff interviews for 1 of 3 employee files reviewed for Nurse Aide (NA # 8), the facility failed to conduct a thorough investigation on the history of prospective staff, including required background checks, prior to the hire date. The findings include: On 8/14/2025 at 12:55 PM, an interview and review of employee files with the Human Resources Director identified NA#8 was hired on 4/12/2024. She was certified as a nursing aide since 3/07/2023. Although NA#8's employee file contained signed employee consents for background checks, the file did not contain documentation of a completed state or federal background check, including fingerprint-based screening through the Applicant Background Check Management System (ABCMS). The Human Resources Director indicated she was unable to retrieve evidence of an ABCMS screening on the online portal. The Human Resource Director indicated background checks, including the ABCMS screening, are done by the facility prior to employing staff and could not identify a reason for NA#8 not having one. Furthermore, the Human Resource Director indicated NA#8 would be removed from the schedule until NA#8 completes an ABCMS screening. On an interview on 8/14/2025 at 1:35 PM, the Administrator could not explain why NA # 8 did not have a background check or an ABCMS screening prior to being hired. The Administrator indicated that when the Human Resource Director began working at the facility, she had been auditing employee records, and the facility would ensure employee records are audited for background checks. Although requested, the facility was unable to produce a policy for pre-employment screening. However, the facilities abuse policy given during the survey identified a section for pre-hire screening, which indicated the facility would ensure an active license or certification and would review regulatory action reports. The abuse policy did not identify a process for ensuring background checks and ABCMS screenings were completed.

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, policy review and staff interviews for 1 of 6 residents reviewed for abuse (Resident # 2), the facility failed to follow up on and report a potential allegation of abuse. The findings include: Resident #2's diagnoses included quadriplegia (paralysis of all four extremities), anxiety, and depression. The Medicare 5-day MDS assessment dated [DATE] identified Resident #2 was cognitively intact and had not exhibited behavioral symptoms towards self or others. The MDS assessment further indicated Resident #2 was dependent for toileting and bathing and always incontinent of bowel. A care plan dated 7/9/2025 identified Resident #2 required total assistance for activities of daily living (ADL). Interventions included the assistance of one staff member with incontinence care and using a hands-free system to use the call light. 0n 8/6/2025 at 3:20 PM during a screening interview, Resident #2 indicated that 3 to 4 months ago, a nursing aide whose name she/he did not recall came in during a morning shift around 11:00 AM to provide a bath. Resident #2 indicated he/she refused care, but the nursing aide proceeded to wash him/her anyway. Resident #2 indicated she/he complained to his/her nurse that day (LPN#1) and to the DNS at the time (RN#5). Resident #2 indicated she/he had not seen the nurse aide again since the incident and indicated she/he did not know what LPN#1 and RN#5 had done about the incident. On 8/11/2025 at 11:00 AM, an interview with LPN #2, who was taking care of Resident #2, indicated she had heard about the incident but could not recall from where. LPN # 2 further indicated she did not know any details. However, LPN#2 indicated she thought it had occurred on a weekend when she was off. On 8/11/2025 at 11:44 AM, an interview with LPN#1 identified that sometime in the end of March 2025 or April 2025 (LPN#1 could not recall the exact date), NA#8 came to her to inform her that Resident #2 was refusing care from NA#8. LPN#1 indicated she spoke to Resident #2, who indicated NA#8 was trying to change him/her against his/her will. Additionally, LPN#1 indicated Resident #1 had informed her that NA#8 had changed him/her against his/her will during the night therefore she/he want NA#8 taking care of him/her anymore. LPN#1 indicated she had the nursing aides switch assignments so NA#8 would not be assigned to Resident #2 and then informed RN#5 about the resident's concern. LPN#1 did not recall which nursing aide took over Resident #2's care. LPN#1 indicated that when there is an allegation of abuse, staff are supposed to contact the DNS, and the DNS handles things from there. LPN#1 further indicated that she did not follow up with the resident afterwards and did not recall if the DNS had spoken to Resident #2 after being informed. LPN#1 indicated she did not tell the supervisor of the shift because she had already told the DNS. On 8/11/2025 at 12:23 PM, an interview with the Administrator indicated he was not aware of an incident between NA#8 and Resident #2. The Administrator also identified RN#5's last day working as a DNS was on 6/30/2025 and the current DNS served as Assistant Director of Nursing Services (ADNS) from 5/15/2025 to 7/21/2025 and then assumed DNS role on 7/22/2025. On 8/11/2025 at 2:18 PM, an interview with RN#5 identified RN#5 did not recall an incident between NA#8 and Resident #2 and indicated that had there been an incident, she would have written an incident report. The written report would been left on her desk after she left the facility. RN#5 indicated that when there was an allegation of staff-to-resident abuse, the process included: staff write statements, notifying the social worker, and removing the staff member from the schedule pending investigation. A review of nursing notes and social work notes from 3/15/2025 to 5/30/2025 failed to identify an incident where Resident#2 refused care and complained of being provided peri care against his/her will. A review of facility accident and incident reports from 1/1/2025 to 8/6/2025 for Resident #2 failed to identify an incident between NA#8 and Resident #2 or any other incident of potential abuse. A review of the facility's state's reportable events data since the last recertification survey on 12/21/2023 failed to identify an allegation of abuse for Resident #2. On 8/13/2025 at 10:30 AM, an interview with the DNS indicated she was not aware of an incident between Resident #2 and NA#8, but indicated that if a resident refuses care, staff should document it and reapproach later. Additionally, the DNS indicated there were no other incident and accident reports for Resident #2 from 1/1/2025 to 8/6/2025 other than what was already provided. On 8/14/2025 at 9:13 AM, an interview with NA#8 identified NA#8 denied providing care to Resident #2 without his/her consent. NA#8 did indicate that there was an incident a few months prior (NA#8 could not recall the exact day or month) where she was providing incontinence care to Resident #2 after Resident #2 had agreed to be peri care, but Resident #2 complained that NA#8 was taking too long and yelled at her to stop and leave. NA#8 indicated she stopped and reported to LPN#1 the resident did not want her/him (NA #8) taking

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, policy review and staff interviews for 1 of 6 residents reviewed for abuse (Resident # 2), the facility failed to conduct a thorough investigation regarding an allegation of mistreatment. The findings include: Resident #2's diagnoses included quadriplegia (paralysis of all four extremities), anxiety, and depression. The Medicare 5-day MDS assessment dated [DATE] identified Resident #2 was cognitively intact and had not exhibited behavioral symptoms towards self or others. The MDS assessment further indicated Resident #2 was dependent for toileting and bathing and always incontinent of bowel. A care plan dated 7/9/2025 identified Resident #2 required total assistance for activities of daily living (ADL). Interventions included the assistance of one staff member with incontinence care and using a hands-free system to use the call light. 0n 8/6/2025 at 3:20 PM during a screening interview, Resident #2 indicated that 3 to 4 months ago, a nursing aide whose name she/he did not recall came in during a morning shift around 11:00 AM to provide a bath. Resident #2 indicated he/she refused care, but the nursing aide proceeded to wash him/her anyway. Resident #2 indicated she/he complained to his/her nurse that day (LPN#1) and to the DNS at the time (RN#5). Resident #2 indicated she/he had not seen the nurse aide again since the incident and indicated she/he did not know what LPN#1 and RN#5 had done about the incident. On 8/11/2025 at 11:00 AM, an interview with LPN #2, who was taking care of Resident #2, indicated she had heard about the incident but could not recall from where. LPN # 2 further indicated she did not know any details. However, LPN#2 indicated she thought it had occurred on a weekend when she was off. On 8/11/2025 at 11:44 AM, an interview with LPN#1 identified that sometime in the end of March 2025 or April 2025 (LPN#1 could not recall the exact date), NA#8 came to her to inform her that Resident #2 was refusing care from NA#8. LPN#1 indicated she spoke to Resident #2, who indicated NA#8 was trying to change him/her against his/her will. Additionally, LPN#1 indicated Resident #1 had informed her that NA#8 had changed him/her against his/her will during the night therefore she/he want NA#8 taking care of him/her anymore. LPN#1 indicated she had the nursing aides switch assignments so NA#8 would not be assigned to Resident #2 and then informed RN#5 about the resident's concern. LPN#1 did not recall which nursing aide took over Resident #2's care. LPN#1 indicated that when there is an allegation of abuse, staff are supposed to contact the DNS, and the DNS handles things from there. 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RN#5 indicated that when there was an allegation of staff-to-resident abuse, the process included: staff write statements, notifying the social worker, and removing the staff member from the schedule pending investigation. On 8/13/2025 at 10:30 AM, an interview with the DNS indicated she was not aware of an incident between Resident #2 and NA#8, but indicated that if a resident refuses care, staff should document it and reapproach later. Additionally, the DNS indicated there were no other incident and accident reports for Resident #2 from 1/1/2025 to 8/6/2025 other than what was already provided. On 8/14/2025 at 9:13 AM, an interview with NA#8 identified NA#8 denied providing care to Resident #2 without his/her consent. 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