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	09/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to notify a provider when an antibiotic used to treat a Urinary Tract Infection was omitted five (5) times for various reasons. The findings include:Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to notify a provider when an antibiotic used to treat a Urinary Tract Infection was omitted five (5) times for various reasons. The findings include: Resident #1's diagnoses included Alzheimer's disease and type 2 diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of eight (8) out of fifteen (15) indicating Resident #1 had some memory recall deficits, was dependent on staff for personal hygiene and toileting and incontinent of bowel and bladder. The Resident Care Plan dated 5/21/25 identified that Resident #1 was often incontinent of bowel and bladder and at risk for. Interventions directed to offer and encourage fluids often throughout the day, encourage and offer toileting as needed and if the resident reports burning on urination, has an elevated temperature or reported flank pain, notify a provider, as the resident may have a urinary tract infection. The nurse's note dated 8/13/25 at 4:11 AM identified Resident #1 returned from the hospital and was diagnosed with a urinary tract infection and started on cefuroxime (an antibiotic) and the Advanced Practice Registered Nurse (APRN) was notified. A physician's order dated 8/13/25 directed to administer the antibiotic cefuroxime axetil 500 milligrams (mg) tablet, give one (1) tablet two (2) times a day for a urinary tract infection for ten (10) days. Review of the August 2025 Medication Administration Record (MAR) identified the cefuroxime axetil was not administered five (5) times to Resident #1 on: -8/13/25 at 9:00 AM reporting the medication was unavailable and to see the nurse's note.-8/15/25 at 9:00 AM reporting the antibiotic was held and to see nurse's note.-8/15/25 at 5:00 PM reporting Resident #1 was on a Leave of Absence (LOA). -8/21/25 at 9:00 AM reporting the antibiotic was held and to see nurse's note.-8/22/25 at 9:00 Am reporting the antibiotic was held and to see nurses note. Review of the nurse's notes dated 8/13/25, 8/15/25 and 8/21/25 identified Resident #1 had refused the 9:00 AM doses of cefuroxime and there were no notes documented regarding the 8/15/25 dose at 5:00 PM or the 8/22/25 dose at 9:00 AM. Upon further review from 8/13/25 through 8/22/25 the nurse's notes failed to reflect documentation the charge nurses informed the nursing supervisors or the provider was notified of the missed administrations. Interviews with LPN #1 and LPN #2 on 9/17/25 identified they were unaware the provider had to be notified for each missed dose of a medication. The nurses explained they had not notified the nursing supervisor or the provider when they did not administer the cefuroxime axetil on 8/13/25, 8/15/25, 8/21/25 or 8/22/25. LPN #2 identified she could not recall why on 8/22/25 she did not document Resident #1's refusal to take the cefuroxime axetil in the nurse's notes reporting she should have. Interview with the APRN on 9/17/25 at 1:28 PM identified she was unaware and had not been notified Resident #1 missed five (5) doses of the cefuroxime axetil due to refusal and going on an LOA, stating had she known, she could have changed the time of the administrations to allow the staff to reapproach Resident #1 at a later time and/or extended the duration of the cefuroxime axetil treatment. The APRN identified t a provider should have been notified for each missed medication dose. Interview with the Director of Nursing (DON) on 9/17/25 at 2:37 PM identified the provider should have been notified for each missed dose medication and each missed dose was documented to include why the medication was not administered and who was notified following the omission of each medication and any new orders obtained. The DON reported when a resident refuses a medication, nursing should be educating the resident on its importance and then reapproaching the resident if they continue to refuse and documenting each reapproach and interaction and identified that she was unsure why that had not been done. Review of the Medication Administration policy (undated) directed, in part, that all medications shall be administered safely and accurately in accordance with physician's orders, facility protocols and applicable state and federal regulations. Document the administration in the MAR immediately after giving the medication. Monitor residents for therapeutic side effects and potential side effects of medications. All resident refusals of medication must be documented in the medical record, including the reason for refusal if provided, and the provider must be notified as appropriate. If medication is not available at the time of administration: notify the physician immediately and request guidance or an alternative order, inform he

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for admission orders, the facility failed to ensure an appointment was scheduled with an outside specialty provider per admission orders. The findings include:Resident #1's diagnoses included Alzheimer's disease, type 2 diabetes mellitus and myotonic muscular dystrophy (a genetic disorder affecting the muscles and causing progressive weakness and muscle stiffness). The Nursing admission assessment dated [DATE] at 7:33 PM identified that Resident #1 was alert with good memory recall and required staff assistance with positioning and transfers. The Resident Care Plan (RCP) dated 5/7/25 identified that Resident #1 has a diagnosis of diabetes and is at risk for hypo/hyperglycemia. Interventions included watching for any acute signs/symptoms of hypo/hyperglycemia and reporting to the provider, checking the resident's blood sugar with any diabetic signs and symptoms including sweating, confusion or changes in mental status. A nurse's note dated 5/7/25 at 8:58 PM identified that Resident #1 was newly admitted to the facility at 4:00 PM and required an Endocrinology appointment within one (1) to two (2) weeks. A physician's order dated 5/7/25 directed that Resident #1 required a follow-up appointment with Endocrinology within 1 to 2 weeks and directed to discontinue the order when the appointment was obtained. Review of the clinical record from 5/8/25 through 8/23/25 failed to identify that an endocrinology appointment was ever scheduled or that the resident was seen by endocrinology. Review of the Medication Administration Records from May 2025 through August 2025 identified that nursing continued to sign off the 5/7/25 order identifying that Resident #1 required an endocrinology appointment daily at 9:00 AM until 8/22/25 (3.5 months later). Interview with Person #1 (Endocrinology office) on 9/17/25 at 11:18 AM identified that Resident #1 had not been seen in their office from May to August 2025 and reported that no one from the facility had ever called them to set up an appointment. Interview with Registered Nurse (RN) #5 (3:00 PM to 11:00 PM Nursing Supervisor) on 9/17/25 at 3:13 PM identified that when a resident is admitted to the facility with hospital paperwork stating they require an appointment with an outside provider, she notifies the provider, notates it on the facility's 24-hour report and then enters an order that shows up on the MAR so that the charge nurse is aware that they need to schedule the appointment. RN #5 identified that the charge nurse is responsible for scheduling the appointment within 72-hours and reported that if they don't have time, it's their responsibility to notify the nursing supervisor for assistance. She identified that the endocrinology appointment should have been scheduled by the facility, and she was unsure why it had not been. Interview with the Director of Nursing (DON) on 9/17/25 at 2:41 PM identified that the facility doesn't utilize secretaries or unit managers, so the charge nurses and nursing supervisors are responsible for making appointments and setting up transportation for residents who require appointments outside of the facility. She reported that although she was not the DON at the time of Resident #1's admission and she was unaware that the resident required an endocrinology appointment, nursing staff should have followed the physician's order and ensured that the appointment was scheduled as directed and that coordination of medical care was preserved for the resident. The DON identified that staff should have scheduled the appointment within 48 to 72 hours, and she was unsure why staff continued signing off the order daily for three (3) months without scheduling the appointment. Although requested, policies on following physician's orders and scheduling offsite provider appointments were 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for a change in condition, the facility failed to ensure a complete and accurate clinical record to include medical care provided prior to a transfer to the hospital. The findings include:Resident #1's diagnoses included Alzheimer's disease, type 2 diabetes mellitus and myotonic muscular dystrophy (a genetic disorder affecting the muscles and causing progressive weakness and muscle stiffness). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of eight (8) indicative of moderately impaired cognition and required substantial assistance for bed mobility and was dependent on staff for personal hygiene and toileting. The Resident Care Plan (RCP) dated 8/18/25 identified that Resident #1 has a diagnosis of diabetes and is at risk for hypo/hyperglycemia. Interventions included watching for any acute signs/symptoms of hypo/hyperglycemia and reporting to the provider, checking the resident's blood sugar with any diabetic signs and symptoms including sweating, confusion or changes in mental status. A nurse's Situation Background Assessment and Recommendation (SBAR) dated 8/23/25 at 9:38 AM identified that the resident was observed laying in his/her bed only responsive to a chest rub which produced slight facial grimacing. It reported that the resident's breathing was labored and the heart rate was tachycardiac (abnormally fast) at 125 beats per minute, skin was pale and cold to touch and appears very weak and cachectic (muscle wasting) with decreased endurance and sharp bony prominences. It identified that the family was notified, the provider was notified and an order was obtained to transfer the resident to the Emergency Department (ED) for evaluation. Although the SBAR identified that the resident was barely responsive, skin was pale and cold to touch, and the resident had a diagnosis of diabetes, neither a body temperature nor a blood sugar were documented as obtained or communicated to the provider. Review of the clinical record failed to identify a body temperature or a blood sugar documented for Resident #1 on 8/23/25. Review of hospital ED notes dated 8/23/25 identified that the resident was found to be febrile (having a fever) of 102.2 degrees Fahrenheit (moderate grade fever) and a blood glucose level of 503 (high blood sugar that requires immediate medical care). Interview with RN #2 on 9/17/25 at 1:41 PM identified that on 8/23/25, she was the nurse assigned to Resident #1 when the Nurse Aide (NA #2) notified her that the resident was unresponsive. RN #2 reported that she did a brief assessment on the resident and then notified RN #1 (Nursing Supervisor), who called the provider and then started the paperwork to transfer the resident to the ED as she (RN #5) did a more thorough assessment and obtained vital signs and a blood sugar on the resident. RN #2 identified that although she didn't document the blood sugar or the body temperature, reporting that she should of before she left for her shift that day, stated that due to Resident #1's condition, she forgot to fully document, stating she left out important documentation that were important to communicate in the resident's medical care to the hospital. RN #2 identified that she could not recall the resident having a fever and reported that she believed the resident's blood sugar was 110 (within normal range) prior to sending the resident to the ED. Interview with the Advanced Practice Registered Nurse (APRN) on 9/17/25 at 1:28 PM identified that for Resident #1 who was known to be diabetic and on insulin and for a resident who was currently being treated with antibiotics for a UTI, when the resident was observed to be unresponsive, nursing should have immediately taken a full set of vital signs, including a body temperature and a blood glucose level and communicated it to the provider and the Emergency Medical Staff (EMS) upon transport to the hospital and then documented it so that facility providers could review. Interview with the Director of Nursing (DON) on 9/17/25 at 2:41 PM identified that nursing staff is responsible for documenting in the clinical record for a resident as close to the event that the care takes place but no later than the end of the shift. The DON reported that RN #2 should have documented Resident #1's body temperature and blood sugar in the clinical record on 8/23/25 and she was unaware that it had not been done. Review of the Nursing Documentation policy (undated) directed, in part, that documentation should be completed as soon as possible after care is provided, assessments are conducted, or any significant event occurs, ideally within the same shift. In extenuating circumstances, documentation may be entered at a later time, but it must be clearly indicated as such to maintain transparency and accuracy. All entries must be factual, complete, and reflect the resident's current condition and care provided. Document any changes in the resident's condition, new symptoms, or reactions to treatments immediately and include any actions taken (e.g., physician