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	11/17/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and facility policy, and interviews for one of two residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was assessed timely upon readmission for special needs and adaptive devices for a resident with a known history of requiring a specialized drinking cup. The failure resulted in a second-degree burn measuring seventeen (17) centimeters (cm) by nine-point-five (9.5) cm. The findings include:Resident #1 was admitted to the facility with diagnoses that included stroke, diabetes mellitus, peripheral vascular disease, congestive heart failure and chronic obstructive pulmonary disease with dependance on supplemental oxygen. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated moderate cognitive impairment, required staff to set up for meals. The Resident Care Plan (RCP) dated 9/24/2025 identified an alteration in activities of daily living, and was at risk for aspiration. Interventions directed to set up meals, and to keep head of bed at 90 degrees while eating. Physician orders dated 9/13/2025 directed use of a Kennedy cup (adaptive drinking cup with a screw on lid that prevents spills even when turned upside down) for all hot and cold liquids. Facility discharge/transfer documentation dated 10/9/2025 identified Resident #1 was transferred to the hospital due to a change in respiratory status. The documentation directed Resident #1 required use of a Kennedy cup for all hot and cold liquids. A nursing re-admission assessment form completed by RN #1 dated 10/23/2025 at 1:30 PM identified Resident #1 was readmitted to the facility without any changes in functional status. A nursing SBAR (change in condition) note dated 10/23/2025 at 7:29 PM identified Resident #1 had spilled coffee, noted discoloration on the right thigh with reports of pain level of four (4) out of ten (10) where 10 was the worst possible pain. Review of the NA documentation of Activities of Daily Living (ADL) for October 2025 identified that it included an intervention to provide Resident #1 with a [NAME] Cup with all meals for all fluids. A facility reportable event (RE) form dated 10/23/2025 at 5:00 PM (the day of readmission to the facility) identified Resident #1 removed a coffee lid from the cup and spilled the coffee on her/his right thigh. An RN assessment was completed with redness noted initially to the site then a blister formation. Physician order dated 10/24/2025 (the day after the incident) directed use of a Kennedy cup for all hot and cold liquids. The RE summary dated 10/27/2025 identified Resident #1 called for NA #3 to report that she/he had spilled coffee on her/his right thigh. Resident #1 identified he/she removed the coffee lid and while attempting to remove the lid some of the coffee spilled on him/her. Initial redness was noted followed by blistering later in the shift. The area measured seventeen (17) cm by nine-point-five (9.5) cm. The temperature of the coffee served from the coffee dispenser was tested at 171 degrees Fahrenheit. Upon report of the spill, an RN assessment was performed and a cool compress was applied. The APRN and responsible party were notified. Bacitracin was initially ordered then the order was changed to Silvadene (cream used to prevent and treat wound infections in residents with burns) daily. A therapy screen was ordered, and Resident #1 was given a Kennedy cup to prevent future occurrences. A wound care MD specialist note dated 10/28/2025 identified the wound was a right lateral hip burn, full thickness (of the skin) measuring twelve (12) cm in length by eight-point-five (8.5) cm in width and zero (0) depth with a calculated area of one-hundred and two (102) square cm. The wound base was seventy-five (75) percent (%) slough (yellowish stringy dead tissue). Resident #1 reported pain at five (5) on a scale of ten (10). Interview with OT #1 on 11/17/2025 at 10:40 AM identified she evaluated Resident #1 on 10/24/2025 due to his/her readmission to the facility on [DATE]. OT #1 stated she was unaware of the burn at the time of her evaluation, and based on her knowledge of Resident #1's previous status, she immediately re-ordered the Kennedy cup for all liquids. OT #1 stated Resident #1 had a long history with spilling drinks prior to the transfer to the hospital on [DATE]. OT #1 stated Resident #1 had required use of a Kennedy cup since August 2024. She identified that the order for the Kennedy cup had been discontinued when Resident #1 was transferred to the hospital on [DATE] and the order was not re-activated when Resident #1 returned to the facility (from the hospital) on 10/23/2025. She did not assess Resident on 10/23/2025 when he/she returned to the facility due to the time of day when Resident #1 was readmitted . OT #1 stated she did not know why the nursing staff did not identify that Resident #1 needed the Kennedy cup for safety upon her/his readmission, and why they did not re-order the use of the Kennedy cup. Interview with NA #3 on 11/17/1015 at 1:00 PM identified she was the Nurse Aide (NA) assigned to Resident #1 on 10/23/2025 and Resident #1 was in bed and was using a regular coffee cup. About 5:00 PM she answered the call light and Resident #1