| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075403 | A. Building<br>B. Wing | 04/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab West Haven | 308 Savin Avenue<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies, and interviews for four of four residents (Resident #7, #8, #9, and #10) reviewed for quality of care, the facility failed to ensure elopement risk assessments were performed at appropriate intervals, and/or the facility failed to ensure an elopement risk assessment was completed accurately/completely. The findings include: Resident #7's diagnoses included mild cognitive impairment and anxiety. The Resident Care Plan dated 2/15/25 identified Resident #7 had impaired memory, recall, and decision-making skills. Interventions directed reminders when confused. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen (3/15), indicating severe cognitive impairment, had no wandering behaviors and ambulated independently with a wheelchair. Clinical record review identified no elopement risk assessments were completed since admission to the facility on 5/19/25 (two years). Review of a nursing re-admission assessment dated [DATE] identified an elopement risk assessment was initiated; however, the assessment was not completed. 2. Resident #8's diagnoses included depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicating resident was cognitively intact. and ambulated independently with a wheelchair. The Resident Care Plan dated 3/3/26 identified Resident #8 an alteration in ADL function (activities of daily living). Interventions directed to assist with ADL's as needed due to resident may fluctuate in his/her ability to perform ADL's due to cognitive status. Clinical record review identified the most recent completed elopement risk assessment for Resident #8 was dated 11/5/2022, with no evidence of a reassessment since that time (3 years and 4 months). A nursing re-admission assessment dated [DATE] referenced a prior elopement risk assessment identifying Resident #8 as not at risk for elopement. Record review failed to identify an elopement risk assessment was completed upon re-admission on [DATE]. 3. Resident #9's diagnoses included adjustment disorder, and anxiety. A nursing assessment dated [DATE] identified Resident #9 had cognitive impairment. An elopement risk assessment was initiated; however, the assessment was not completed, including the final risk determination section. The Resident Care Plan dated 3/25/26 identified Resident #9 is at risk for elopement from the building due to tendency to wander. Interventions directed placement on the secured unit, wander guard per physician orders, and check wander guard placement each shift and functioning per facility policy. Record review failed to identify any elopement assessment was completed since admission on [DATE] (68 days prior). 4. Resident #10's diagnoses included dementia and adjustment disorder. A Nursing admission assessment dated [DATE] identified cognitive impairment. The Resident Care Plan dated 2/28/26 identified Resident #10 at risk for wandering and can be confused and forgetful, at risk for elopement from the building. Interventions directed to apply wander guard per physician orders, orders, and check wander guard placement each shift and functioning per facility policy, and to offer to escort resident if seen heading toward or lingering near an exit door. Clinical record review identified the most recent completed Elopement Risk Assessment for Resident #10 was dated<br>(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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11/25/2024 (1 year and 5 months prior), with no evidence of a reassessment since that time. Interview and record reviews with RN #1 (Corporate Regional Nurse) on 4/28/26 at 12:15 PM identified nursing staff are responsible for completing elopement risk assessments for residents, and the electronic medical record (PCC) generates alerts when assessments are due. RN #1 stated she expected elopement risk assessments to be completed on admission, readmission, quarterly, and with a change in condition; however, she confirmed the facility policy only requires completion on admission and readmission and does not include a requirement for ongoing or periodic reassessment. RN #1 further stated that elopement risk assessments for Resident #7 and Resident #9 were not completed in full, including the final risk determination section was not completed, and was unable to provide a rationale for the incomplete assessments. RN #1 was also unable to explain how the facility monitors compliance with completion or reassessment of elopement risk assessments. Review of the facility undated Elopement Risk Policy directed in part, all residents are evaluated for risk of elopement on admission and readmission; every resident admitted to the facility will be evaluated for elopement risk. A care plan will be developed and individualized interventions implemented if the resident is identified to be an elopement risk per the Elopement Risk Evaluation. An activated elopement bracelet (wander guard) will be placed on the resident and documented in the medical record if deemed appropriate. Each shift, placement of the elopement bracelet will be verified and documented in the medical record. Functioning of the elopement bracelet will be tested on ce a day by utilizing a tester unit and documented in the medical record. |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, and interviews for three of three residents (Resident #1, #4 and #5) reviewed for quality of care, the facility failed to ensure the physician/designee orders were reviewed and renewed at least once every 60 days. The findings included: Resident #1's diagnoses included dementia, and delusional disorders. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen, indicative of moderate cognitive impairment and required assistance with ADLs and ambulated independently. The Resident Care Plan (RCP) dated 12/18/2025 identified and alteration in ADL function. Interventions directed to assist as needed. Record review identified Resident #1 was on a 60-day schedule for review and renew of physician orders. Additional review identified the last signed orders were dated September 2025; physician orders were not signed by MD #1 beginning October 2025 through February 2026. Although requested facility failed to provide any additional signed physician orders (paper or electronic) for Resident #1. Resident #4's diagnoses included severe protein calorie malnutrition, chronic pulmonary disease and history of transient ischemic attack (mini-stroke). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #5 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment and required assistance for ADLs. The Resident Care Plan (RCP) dated 1/18/2026 identified Resident #4 needed assistance with ADLs. Interventions directed to assist as indicated and transfer per MD orders. Record review identified Resident #4 was on a 60-day schedule for review and renew of physician orders. Additional review identified the last signed orders were dated September 2025; physician orders were not signed by MD #1 beginning October 2025 through February 2026. Although requested facility failed to provide any additional signed physician orders (paper or electronic) for Resident #4. Resident #5's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #5 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment and was dependent ADLs. The Resident Care Plan (RCP) dated 3/6/2026 identified an alteration in ADLs, and interventions directed to assist as needed and transfer per MD orders. Record review identified Resident #5 was on a 60-day schedule for review and renew of physician orders. Additional review identified the last signed orders were dated September 2025; physician orders were not signed by MD #1 beginning October 2025 through February 2026. Although requested facility failed to provide any additional signed physician orders (paper or electronic) for Resident #5. Interview and record review with the DNS and Corporate RN #1 on 4/20/2026 at 2:30 PM identified physician orders should be signed at least every 60-days. MD #1 was new to signing electronic orders and had been educated how to sign them, but indicated the orders for Resident #1, #4 and #5 were not signed. Resident #1 and Resident #4's orders were last signed in September 2025. RN #1 further stated she was unable to identify when Resident #5's orders were last signed (they were not signed during September 2025). Interview failed to identify why the facility did not identify the orders were not signed timely and failed to identify a facility process to ensure orders were signed timely. Subsequent to surveyor inquiry, interview and record review with the DNS and RN #1 on 4/21/2026 at 12:32 PM, identified the orders were now signed. Although requested, the facility did not provide a policy for surveyor review related to physician orders, or electronic signatures. |