

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2025
NAME OF PROVIDER OR SUPPLIER  Apple Rehab Uncasville		STREET ADDRESS, CITY, STATE, ZIP CODE  5 Richard Brown Drive Uncasville, CT 06382	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to follow physician's orders to have two-half siderails and padded siderails on the bed . The findings include:</p> <p>Resident #1's diagnoses included Alzheimer's disease with late onset (a type of dementia that affects memory, thinking and behavior), dementia with behavioral disturbances, age-related cataract (clouding of the normally clear lens of the eye that can cause blurry vision), bilateral sensorineural hearing loss (permanent hearing loss caused by damage to the inner ear or the nerve from the ear to the brain) and difficulty in walking.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted identifying long and short-term memory problems and was able to recall staff names and faces only indicative of moderately impaired cognition and required staff supervision for bed mobility, transfers and ambulation. Additionally, it identified that Resident #1 had not had any recent falls.</p> <p>A physician's order dated 11/28/23 directed for Resident #1 to have siderails, two-half up for mobility and safe transfers out of bed and for staff to check every shift.</p> <p>A physician's order dated 1/24/25 directed for Resident #1 to be on seizure precautions including a low bed with fall mats and padded side rails every shift.</p> <p>The Resident Care Plan (RCP) updated on 1/22/25 (originally dated 10/30/19) identified that Resident #1 is at risk for falls due to psychotropic medication, chronic pain, poor safety awareness, impaired vision, hard of hearing and seizure precautions with interventions that included checking on the resident as needed, as he/she often does not use the call bell to summon assistance, ensuring the bed is in the lowest position when care is not being provided, keeping frequently needed items within reach and encouraging the resident to request help with picking up items, fall mat to be placed on the window side of the bed when the resident is in bed and seizure precautions including a low bed with fall mats and padded rails.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations and interview with the DNS on 2/10/25 at 10:24 AM, identified the bed in Resident #1's room as a low bed without any side rails attached to the frame of the bed and no side rail padding was observed in the room. Two (2) black floor mats were observed, one in place on the floor to the left side of the bed (window side) and the other was noted to be propped up against the back wall next to the right side of the headboard. She reported that when the bed was switched out for a low bed on 1/24/25, it must not have been communicated to maintenance staff to put side rails on the low bed and although both the side rails and side rail padding was a physician's order, she was unsure why nursing staff had not noticed that they were not in place to the bed. Further, she identified that Resident #1 had not had a fall since 1/18/25.</p> <p>Review of the January 2025 Treatment Administration Record (TAR) identified that since 1/24/25, nursing staff signed off that they checked that the two-half side rails to Resident #1's bed were in place 23 out of 23 (100 %) shifts.</p> <p>Review of the January 2025 Treatment Administration Record (TAR) identified that nursing staff signed off that seizure precautions including a low bed with fall mats and padded side rails were in place 23 out of 23 (100 %) shifts.</p> <p>Review of the February 2025 Treatment Administration Record (TAR) identified that nursing staff signed off that they checked that the two-half side rails to Resident #1's bed were in place 28 out of 28 (100 %) shifts, which included the 7:00 AM to 3:00 PM shift on 2/10/25.</p> <p>Review of the February 2025 Treatment Administration Record (TAR) identified that nursing staff signed off that seizure precautions including a low bed with fall mats and padded side rails were in place 28 out of 28 (100 %) shifts, which included the 7:00 AM to 3:00 PM shift on 2/10/25.</p> <p>Interview with RN #2 on 2/10/25 at 11:54 AM identified that she worked the 3:00 PM to 11:00 PM shift on 1/25/25, 1/30/25, 2/3/25, 2/5/25, 2/7/25 and 2/9/25 and although she signed off on the TAR that both the two-half side rails were in place, as well as seizure precautions including a low bed with fall mats and padded side rails were in place, she was not aware that the two-half side rails nor the side rail padding had not been in place since 1/24/25 when the bed was switched out to a low bed, stating she should have checked prior to signing off the orders but that she didn't and was unsure why.</p> <p>Interview with LPN #2 (7:00 AM to 3:00 PM nurse on 2/10/25) on 2/10/25 at 2:13 PM identified that although she signed off the orders on the TAR for 2/10/25 that both of the two-half side rails were in place to Resident #1's bed, as well as seizure precautions including a low bed with fall mats and padded side rails were in place, she stated she was busy and did not actually check to ensure that the two-half side rails nor the side rail padding was in place. She reported that after signing off the orders in the TAR she realized the resident didn't have the side rails on the bed when she heard staff talking on the unit.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further interview with the DNS on 2/10/25 at 2:25 PM identified that when Resident #1's bed was changed to a low bed, she was responsible for communicating to maintenance that the new bed required side rails to be put on, but stated she was unsure if that happened, reporting that subsequent to surveyor inquiry, she spoke with maintenance and the side rails and padding were now in place to Resident #1's bed. She identified that she expects all nursing staff to be reading and following physician's orders at all times, as well as verifying that the interventions are in place as ordered and stated she was unsure why staff had been signing off the orders for the side rails and side rail padding when they weren't in place to Resident #1's bed.</p> <p>Although requested, a facility policy for following physicians' orders was not provided.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for nursing documentation, the facility failed to ensure a complete and accurate medical record for a resident when staff documented that side rail and side rail padding interventions were in place that were identified to not be in place per physician's orders. The findings include:</p> <p>Resident #1's diagnoses included Alzheimer's disease with late onset (a type of dementia that affects memory, thinking and behavior), dementia with behavioral disturbances, age-related cataract (clouding of the normally clear lens of the eye that can cause blurry vision), bilateral sensorineural hearing loss (permanent hearing loss caused by damage to the inner ear or the nerve from the ear to the brain) and difficulty in walking.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status conducted identifying long and short-term memory problems and was able to recall staff names and faces only indicative of moderately impaired cognition and required staff supervision for bed mobility, transfers and ambulation. Additionally, it identified that Resident #1 had not had any recent falls.</p> <p>A physician's order dated 11/28/23 directed for Resident #1 to have siderails, two-half up for mobility and safe transfers out of bed and for staff to check every shift.</p> <p>A physician's order dated 1/24/25 directed for Resident #1 to be on seizure precautions including a low bed with fall mats and padded side rails every shift.</p> <p>The Resident Care Plan (RCP) updated on 1/22/25 (originally dated 10/30/19) identified that Resident #1 is at risk for falls due to psychotropic medication, chronic pain, poor safety awareness, impaired vision, hard of hearing and seizure precautions. Interventions included checking on the resident as needed, as he/she often does not use the call bell to summon assistance, ensuring the bed is in the lowest position when care is not being provided, keeping frequently needed items within reach and encouraging the resident to request help with picking up items, fall mat to be placed on the window side of the bed when the resident is in bed and seizure precautions including a low bed with fall mats and padded rails.</p> <p>Observations and interview with the DNS on 2/10/25 at 10:24 AM, identified the bed in Resident #1's room as a low bed without any side rails attached to the frame of the bed and no side rail padding was observed in the room. Two (2) black floor mats were observed, one in place on the floor to the left side of the bed (window side) and the other was noted to be propped up against the back wall next to the right side of the headboard. She reported that when the bed was switched out for a low bed on 1/24/25, it must not have been communicated to maintenance staff to put side rails on the low bed and although both the side rails and side rail padding was a physician's order, she was unsure why nursing staff had not noticed that they were not in place to the bed.</p> <p>Review of the January 2025 Treatment Administration Record (TAR) identified that since 1/24/25, nursing staff signed off that they checked that the two-half side rails to Resident #1's bed were in place 23 out of 23 (100 %) shifts.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the January 2025 Treatment Administration Record (TAR) identified that nursing staff signed off that seizure precautions including a low bed with fall mats and padded side rails were in place 23 out of 23 (100 %) shifts.</p> <p>Review of the February 2025 Treatment Administration Record (TAR) identified that nursing staff signed off that they checked that the two-half side rails to Resident #1's bed were in place 28 out of 28 (100 %) shifts, which included the 7:00 AM to 3:00 PM shift on 2/10/25.</p> <p>Review of the February 2025 Treatment Administration Record (TAR) identified that nursing staff signed off that seizure precautions including a low bed with fall mats and padded side rails were in place 28 out of 28 (100 %) shifts, which included the 7:00 AM to 3:00 PM shift on 2/10/25.</p> <p>Interview with RN #2 on 2/10/25 at 11:54 AM identified that she worked the 3:00 PM to 11:00 PM shift on 1/25/25, 1/30/25, 2/3/25, 2/5/25, 2/7/25 and 2/9/25 and although she signed off on the TAR that both the two-half side rails were in place, as well as seizure precautions including a low bed with fall mats and padded side rails were in place, she was not aware that the two-half side rails nor the side rail padding had not been in place since 1/24/25 when the bed was switched out to a low bed, stating she should have checked prior to signing off the orders but that she didn't and was unsure why. She reported that documentation in the clinical record should always be complete and accurate.</p> <p>Interview with LPN #2 (7:00 AM to 3:00 PM nurse on 2/10/25) on 2/10/25 at 2:13 PM identified that although she signed off the orders on the TAR for 2/10/25 that both of the two-half side rails were in place to Resident #1's bed, as well as seizure precautions including a low bed with fall mats and padded side rails were in place, she stated she was busy and did not actually check to ensure that the two-half side rails nor the side rail padding was in place. She reported that after signing off the orders in the TAR she realized the resident didn't have the side rails on the bed when she heard staff talking on the unit. She reported that documentation in the clinical record should always be complete and accurate and that her documentation on 2/10/24 was not accurate.</p> <p>Further interview with the DNS on 2/10/25 at 2:25 PM identified that when Resident #1's bed was changed to a low bed, she was responsible for communicating to maintenance that the new bed required side rails to be put on, but stated she was unsure if that happened, reporting that subsequent to surveyor inquiry, she spoke with maintenance and the side rails and padding were now in place to Resident #1's bed. She identified that she expects all nursing staff to be reading and following physician's orders at all times, as well as verifying that the interventions are in place as ordered and documenting accurately in the clinical record, stating she was unsure why staff had been signing off the orders for the side rails and side rail padding when they weren't in place to Resident #1's bed but they shouldn't have been.</p> <p>Review of the Nursing Documentation policy (undated) directed, in part, that all entries must be factual, complete, and reflect the resident's current condition and care provided.</p>		