STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075438	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Uncasville	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of four (4) residents (Resident #1 and #2) reviewed for medication administration, the facility failed to ensure licensed nursing staff observed the residents consume prescribed medications prepared by the licensed nursing staff prior to exiting the room. The findings include: 1. Resident #2 's diagnoses included adult failure to thrive, anemia (when the blood doesn't have enough healthy red blood cells and hemoglobin to carry oxygen all throughout the body) and atrial fibrillation (irregular heartbeat). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition (Brief Interview for Mental Status (BIMS) score of 14), required setup assistance for eating and supervision assistance for bed mobility and transfers. The Resident Care Plan (RCP) dated 3/13/25 identified Resident #2 was at risk for pain and discomfort which may impact mobility, mood, behaviors, sleep, Activities of Daily Living functioning and relationships with others. Interventions included watching for nonverbal signs and symptoms of pain and administering medications as ordered. On 6/3/25 at 9:24 AM, LPN #1 was observed preparing prescribed medications for Resident #2, entering Resident #2's room and setting the medication cup on the bedside table as she conversed with Resident #2. LPN #1 was observed applying Lidocaine patches to Resident #2's shoulders and lower back and then exited the room prior to observing Resident #2 consume the medications in the medication cup. Interview and observation with LPN #1 on 6/3/25 at 9:35 identified medications should not be left at the bedside of residents who are not authorized to self-administer medication(s). This surveyor asked LPN #1 if she had ever left medications at the bedside of any other residents and she self-identified that she left medications at the bedside during the 7:00 AM to 3:00 PM shift on 5/11/25 for another resident The medications prepared by LPN #1 for Resident #2 on 6/3/25 at 9:24 AM included: -Three (3) lidocaine patches- one (1) to be applied to each shoulder and one (1) to be applied to the lower back -Psyllium oral powder 25 percent (%) give 15 cubic centimeter (cc) mixed in 8 ounces (oz) of water (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One (1) furosemide 40 milligram (mg) tablet -Two (2) potassium chloride Extended Release (ER) 10 milliequivalent (mEq) tablets -One (1) Preservision AREDS 2 plus multivitamin oral capsule -One (1) sertraline 50 mg tablet -Two (2) Tylenol extra strength 500 mg tablets -One (1) calcium carbonate-vitamin d-mineral 600-400 mg-unit tablet Review of the clinical record failed to identify that Resident #2 was assessed to self-administer oral medications. The DNS was made aware of the above incident on 6/3/25 at 9:47 AM. 2. Resident #1 's diagnoses included anxiety disorder, chronic pain and neoplasm of uncertain behavior of the parathyroid gland (a tumor in the parathyroid gland isn't definitively identified as benign or malignant). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), required setup assistance for eating and was independent with bed mobility and transfers. The Resident Care Plan (RCP) dated 4/3/25 identified Resident #1 had a history of depression and anxiety and took medications to help alleviate the symptoms. The RCP identified Resident #1 had an adrenal mass causing chronic pain. Interventions included providing good pain management and administering medications as ordered. Review of the facility grievance dated 5/27/25 identified, in part, that medications were left at the bedside on 4/30/25 and 5/11/25 and although the complainant could not definitively remember who the nurse was, they thought it was LPN #1. Review of the clinical record failed to identify that Resident #1 was assessed to self-administer oral medications. Review of the facility schedule failed to identify that LPN #1 worked on 4/30/25 but did identify she worked on 5/11/25. Interview with LPN #1 on 6/3/25 at 9:35 AM identified she left Resident #1's morning medications at the bedside during the 7:00 AM to 3:00 PM shift on 5/11/25. She identified that Resident #1's family members were visiting so she left the medications on the bedside table and thought the family would ensure Resident #1 took the medications. She further identified that the family approached her and were upset that she did not administer Resident #1's medications or ensure that he/she had taken the medications. LPN #1 reported that she subsequently administered the medications to Resident #1. She identified that the DNS approached her after the incident and verbally educated her on medication administration. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 6/3/25 at 9:47 AM identified that LPN #2 was the licensed nurse who left Resident #1's medications at the bedside on 4/30/25. She identified that when she asked LPN #2 about the incident, LPN #2 stated, Resident #1 always tells me to leave medications at the bedside, so I did. The DNS identified that licensed nurses should never leave medications at a resident's bedside and they should ensure residents take their medications prior to leaving the room. The DNS identified that both LPN #1 and LPN #2 had been educated on medication administration and that medication administration education was also a part of nursing orientation. She identified that she provided verbal medication administration education to LPN #1 and LPN #2 following the incidents and no disciplinary action was amdinstered. Review of the facility schedule dated 4/30/25 identified that LPN #2 worked the 7:00 AM to 3:00 PM shift on Resident #1's unit. Interview with LPN #2 on 6/3/25 at 10:23 AM identified she was assigned to provide care for Resident #1 on 4/30/25 during the 7:00 AM to 3:00 PM shift. She identified that she floats units and did not often work on that unit. LPN #2 identified that previously, Resident #1 would not take his/her medications in front of her so she would leave his/her medications at the bedside and then circle back to ensure he/she had taken them. She reported that since she had not worked on that unit in a while, she was unaware Resident #1 was allowing staff to administer the medications, therefore, she left the medications at the bedside, as she previously had. She identified that when she went to check on Resident #1, his/her family had arrived to visit and asked why his/her medications were at the bedside, so she administered them at that time. LPN #2 identified that the family reported the incident to the DNS and the DNS provided verbal medication administration education. LPN #2 identified that she should not have left the medications at the bedside but instead should have reapproached Resident #1 if he/she refused to take the medications with her present. Review of Inservice Education titled Med Pass and dated 8/28/24 identified that it is not acceptable to leave medications at the bedside for a resident to self-administer for their convenience or preference. It is unacceptable to leave any medications at the bedside, as it is a safety risk to other residents who may inadvertently gain access to medications not meant for them. If a resident tells a nurse that they are not ready to take their medications at the time they are offered, the only two (2) options are: keeping the medications locked in the medication cart and offering them again at a later time or documenting them as refused, as residents have the right to refuse medications. This education was signed by LPN #2 on 10/4/24. Review of the Nurse Orientation checklist for LPN #1 dated 9/20/24 included education on medication passes and medication administration. Subsequent to surveyor interview on 6/3/25, copy of a disciplinary action for LPN #1 dated 6/3/25 was provided identifying that medications were not administered to a resident per policy and were left at the bedside. Review of the Medication Administration policy (undated) directed, in part, that nursing staff is to administer the medications as per the prescribed route and observe the resident for any adverse reactions or side effects.