STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415120	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Clipper	161 Post Road Westerly, RI 02891

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident with a nephrostomy receives care, consistent with professional standards of practice relative to physician's orders, for 1 of 1 resident who has a percutaneous nephrostomy tube (PCN- an artificial opening created between the kidney and the skin which allows for urinary drainage), Resident ID #4.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/25/2025 alleges in part, that there were concerns with facility staffing and nursing medications errors. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe that the orders are in error or would harm the clients.Record review revealed the resident was admitted to the facility in June of 2025, with a diagnosis including, but not limited to, an artificial opening of urinary tract.1a. Review of a physician's order dated 6/11/2025 to empty Nephrostomy drain and record output every shift.Record review of the June 2025 Medication Administration Record (MAR) record failed to reveal evidence that the drain output was recorded as ordered on the following dates and times:-6/13/2025, 3:00 PM to 11:00 PM-6/14/2025, 7:00 AM to 3:00 PM-6/16/2025, 7:00 AM to 3:00 PM-6/17/2025, 7:00 AM to 3:00 PM-6/23/2025, 7:00 AM to 3:00 PM-6/24/2025, 3:00 PM to 11:00 PM1b. Additional review revealed a physician's order dated 6/12/2025 to use 10 milliliters of Normal Saline (NS) to flush the PCN every day and evening shift to maintain patency. Additional review of the June 2025 MAR failed to reveal evidence that the PCN was flushed as ordered on the following dates and times:-6/13/2025, 3:00 PM to 11:00 PM-6/16/2025, 3:00 PM to 11:00 PM-6/17/2025, 7:00 AM to 3:00 PM1c. Further record review revealed a physician's order dated 6/12/2025 to complete PCN care, remove old dressing, cleanse with normal saline and pat dry, cover with a split sponge gauze and secure with tape, every evening shift every two days. Further review of the June 2025 MAR failed to reveal evidence the above-mentioned treatment was completed on 6/16/2025 as ordered.During a surveyor interview with the Director of Nursing Services on 7/9/2025 at 2:13 PM, she indicated it would be her expectation for the resident's PCN orders to be completed as ordered.

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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Apple Rehab Clipper	161 Post Road Westerly, RI 02891

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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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure the medical care of each resident is supervised by a physician, relative to the providers failure to reconcile the resident's post and pre hospitalization orders relative to the administration of Aranesp (a medication prescribed to treat anemia caused by chronic kidney disease), for 1 of 1 resident reviewed, Resident ID #3. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/25/2025 alleges in part, there are concerns related to medication errors.Record review of an undated facility policy titled, Medication Administration, states in part, .To ensure safe, accurate, and effective administration of medication to the residents, promoting optimal health outcomes while minimizing medication errors .All medication shall be administered safely and accurately in accordance with physician orders . 1a. Record review revealed Resident ID #3 was admitted to the facility in April of 2025 with a diagnosis including, but not limited to, chronic kidney disease (progressive damage and loss of function of the kidneys). Record review revealed a physician's order dated 4/23/2025 for Aranesp 40 micrograms (mcg) to be administered every 28 days. Additionally, the order indicates that the resident's hemoglobin (hgb-the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues) is to be checked prior to administration and if the results are greater than 10.9 grams per deciliter (gm/dL), the medication is to be held. Additional record review revealed that the resident was re-hospitalized in April of 2025 and readmitted to the facility in May of 2025.Record review of a hospital document titled, Discharge summary dated [DATE], revealed a physician's order for Aranesp 25 mcg every 7 days, to be administered upon discharge from the hospital. Record review failed to reveal evidence that the above-mentioned order was reconciled by the nurse with the physician upon the resident's readmission to the facility on 5/6/2025.Record review of a progress note dated 5/7/2025, authored by the resident's physician states in part, .Visit Type: History and Physical .Medication List: medications review and reconciled, please see MARS [Medication Administration Records] .PCC [point click care-electronic medical record] and nursing notes and orders reviewed .Record review failed to reveal evidence that the physician's order for Aranesp 25 mcg every 7 days was reconciled by the physician from the hospital's Discharge summary dated [DATE].Record review of a progress note dated 5/8/2025, authored by the Nurse Practitioner states in part, .Medication List: medications review and reconciled, please see MARS .Record review failed to reveal evidence that the physician's order for Aranesp 25 mcg every 7 days was reconciled by the Nurse Practitioner from the hospital's Discharge summary dated [DATE].Record review of a pharmacy Consultation Report dated 5/8/2025 states in part, CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED . medication review process revealed the following medication dosing discrepancies on the admission orders . Aranesp inject 25 mcg .every 7 days listed on the dc [discharge] summary report reviewed in PCC as Aranesp .every 28 days .please consider clarifying these medication orders .During a surveyor interview on 7/8/2025 at 1:21 PM with the Nurse Practitioner, she indicated that it is her practice to compare the hospital's orders on the discharge summary with the current orders in PCC. Additionally, she revealed she was not aware that the order listed on the discharge summary was not transcribed into the resident's record and should have been. Additionally, she revealed that she did not recall reviewing the hospital discharge summary for Resident ID #3 when s/he was readmitted . Furthermore, she acknowledged that she provided and order on 5/20/2025 to administer Aranesp 25 mcg every 7 days with a with a parameter to hold the Aranesp if the resident's hgb is greater than 10.9 gm/dL. 1b. Record review failed to reveal evidence that a physician's order was in place to obtain a weekly hemoglobin value to determine if the Aranesp should be administered to Resident ID #3 or held.During a surveyor interview on 7/8/2025 at 9:00 AM with the physician, he revealed it is his practice to compare the hospital discharge summary with the current orders that are in Point Click Care (PCC- healthcare software). He acknowledged that he failed to reconcile the Aranesp order on the hospital discharge summary with the Aranesp order that was listed in PCC. Additionally, he revealed that he was not aware that Resident ID #3 did not have an order to routinely monitor his/her hgb, as the previous Aransep order from 4/23/2025 indicated to do so. He revealed that he would have expected an order to be in place. During a surveyor interview on 7/7/2025 at 4:11 PM, with the Director of Nursing Services, she indicated it would be her expectation that Resident ID #3's Aranesp order would have been reconciled by a provider and an order to monitor the resident's hgb weekly would have

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Apple Rehab Clipper	161 Post Road Westerly, RI 02891

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 2 of 5 residents reviewed for medication administration, Resident ID #s 3 and 5.Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 2 of 5 residents reviewed for medication administration, Resident ID #s 3 and 5.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 6/25/2025, alleges in part, that there were concerns with nursing errors.Record review of an undated facility policy titled, Medication Administration, states in part, .To ensure safe, accurate, and effective administration of medication to the residents, promoting optimal health outcomes while minimizing medication errors .All medication shall be administered safely and accurately in accordance with physician orders . 1. Record review revealed Resident ID #3 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, chronic kidney disease (progressive damage and loss of function of the kidneys).Record review of a hospital document titled, Discharge summary dated [DATE], revealed a physician's order for Aranesp (a medication prescribed to treat anemia caused by chronic kidney disease) 25 micrograms (mcg) every 7 days, related to acute kidney injury (an abrupt decrease in kidney function) upon discharge from the hospital. Record review failed to reveal evidence that the above-mentioned order was entered into the resident's record upon his/her admission to the facility. Record review of a pharmacy Consultation Report dated 5/8/2025 states in part, CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED .medication review process revealed the following medication dosing discrepancies on the admission orders .Aranesp inject 25 mcg .every 7 days listed on the dc [discharge] summary report reviewed in PCC [point click care-electronic medical record] as Aranesp .every 28 days .please consider clarifying these medication orders .Record review revealed that the Nurse Practitioner provided an on 5/20/2025 to administer Aranesp 25 mcg every 7 days. Additionally, the order indicates to hold the medication if the resident's hemoglobin (hgb- the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues) is greater than 10.9 grams per deciliter (g/dl). (The normal range for hgb is 14.0-18.0).Review of the May, June and July 2025 Medication Administration Records (MAR) failed to reveal evidence that the Aranesp was administered as ordered on the following dates: -5/21/2025 -5/28/2025 -6/5/2025-6/13/2025-6/27/2025-7/4/2025 Record review failed to reveal evidence that the provider was notified of the above-mentioned missed medication administrations.Record review revealed a physician's order was provided to obtain a complete blood count (CBC- a blood test to obtain the levels of red blood cells and hemoglobin) on the following dates and times:-5/7/2025-5/13/2025-5/16/2025-6/14/2025Record review of the clinical laboratory results report for the above-mentioned orders revealed the following: -5/7/2025 hgb 9.3 (g/dl) -5/13/2025 hgb 9.3 (g/dl) -5/16/2025 hgb 9.4 (g/dl) -6/14/2025 hgb 10.6 (g/dl)These results indicate that the resident should have been administered the Aranesp per the physician's order. During a surveyor interview on 7/8/2025 at 9:00 AM with the physician, he indicated that he was aware of the above mentioned hgb values and that he would have expected the Aranesp to be administered as ordered. Additionally, he indicated that he was not notified that the resident had not received the medication as ordered.2. Record review revealed Resident ID #5 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dementia and displaced fracture of the first and second vertebrae.Record review of a hospital document titled, Continuity of Care [COC] - Post-Acute Facility dated 6/24/2025, revealed the following physician's orders:- Heparin 5,000 units/milliliter (ml) inject 1 ml every 8 hours - Trazodone 50 milligrams (mg) once daily at bedtimeRecord review of the June 2025 Medication Administration Record (MAR) failed to reveal evidence that the resident received the above-mentioned medications on 6/24/2025.Record review failed to reveal evidence that the provider was notified of the above-mentioned missed medication administrations.During surveyor interviews on 7/7/2025 at 4:11 PM and 7/8/2025 at 11:41 AM and 2:13 PM, with the Director of Nursing Services, she indicated it would be her expectation that the physician's orders for Resident ID #s 3 and 5 to have been followed. Additionally, she was unable to provide evidence that Resident ID #s 3 and 5 were kept free from significant medication errors.