

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Apple Rehab Clipper		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0567</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on record review, and resident and staff interviews, it has been determined that the facility failed to obtain written authorization for residents whom the facility is holding personal funds for 2 of 5 residents reviewed, Resident ID #s 4 and 12.</p> <p>Findings are as follows:</p> <p>1. Record review of Resident ID #4 revealed a personal funds balance report dated 5/5/2025 indicating the personal funds account had a balance of \$1.86.</p> <p>Review of the Personal Needs Fund Authorization document revealed the resident had signed the document and it was witnessed on 9/26/2024, directing that his/her personal needs funds be given to him/her.</p> <p>Further record review failed to reveal evidence of a Resident Personal Needs Authorization form authorizing the facility to hold the resident's funds.</p> <p>2. Record review of Resident ID #12 revealed a personal funds balance report dated 5/5/2025 indicating the personal funds account had a balance of \$138.13.</p> <p>Review of the Personal Needs Fund Authorization document revealed the resident had signed the document and it was witnessed on 7/21/2021 directing that his/her personal needs funds be given directly to him/her.</p> <p>Further record review failed to reveal evidence of a Resident Personal Needs Authorization form authorizing the facility to hold the resident's funds.</p> <p>During a surveyor interview with the Business Office Manager on 5/6/2025 at 1:05 PM, she was unable to provide evidence that the Resident Personal Needs Authorization forms were followed for Resident ID #s 4 and 12.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident with a pressure ulcer (localized damage to the skin and/or underlying soft tissue, usually over a bony prominence) receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 2 residents reviewed with wounds, Resident ID #31.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled, Dressing, Dry Clean (NON-STERILE) states in part, Procedure .Put on gloves .remove soiled dressings, remove gloves, wash or sanitize hands with sanitizer and apply gloves . Apply dressing and secure .</p> <p>Record review revealed the resident was readmitted to the facility in September of 2024 with a diagnosis including, but not limited to a stage 4 pressure ulcer (the most severe type of pressure ulcer characterized by full-thickness tissue loss with exposed bone, tendon, or muscle) to the sacral region (located at the base of the spine).</p> <p>Review of a physician's order dated 5/1/2025 revealed an order to clean the stage 4 pressure ulcer with vashe wash (a wound cleanser), pack with alginate AG (silver; an absorbent wound treatment) then apply a collagen sheet (a wound dressing that promotes wound healing by supporting a moist environment and stimulates new tissue growth) daily and as needed.</p> <p>During a surveyor observation of Registered Nurse, Staff A, completing a dressing change of the resident's wound, on 5/7/2025 at 11:00 AM, Staff A put on a pair of gloves, removed the soiled dressing from the resident's wound and did not remove the soiled gloves or perform hand hygiene before applying the clean dressing to the resident's wound. Additionally, Staff A applied a collagen sheet that contained silver; not the collagen sheet that was ordered.</p> <p>During a surveyor interview immediately following the above-mentioned observation, Staff A acknowledged that she did not remove the soiled gloves and did not perform hand hygiene after removing the soiled dressing. She further acknowledged she was wearing the same dirty gloves to apply the clean dressing to the resident's wound. Additionally, Staff A acknowledged that she did not apply the collagen sheet to the resident's wound that was ordered.</p> <p>During a surveyor interview on 5/7/2025 at 1:10 PM with the Director of Nursing Services (DNS), she indicated that she would have expected Staff A to change her gloves, perform hand hygiene, and put on clean gloves before applying the clean dressing to the resident's wound. The DNS was unable to provide evidence that the physician's order for the wound dressing was followed.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview, it has been determined that the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight, for 2 of 6 resident reviewed, who experienced actual weight loss, Resident ID #s 17 and 23. Additionally, the facility failed to follow it's own policy relative to weight monitoring, for 3 of 6 residents reviewed, Resident ID #s 17, 22, and 23.</p> <p>Findings are as follows:</p> <p>Review of a facility policy titled Weight Monitoring states in part, .Accurate and timely measurement of weight changes in all residents is an important tool in assessing their nutritional status .Residents will be weighed weekly for 4 weeks, upon admission and readmission, then monthly .If there is a 5 lbs. [pounds] weight discrepancy (plus or minus) a reweight should be obtained .Significant weight changes will be reported to a physician .</p> <p>1A. Record review revealed Resident ID #23 was re-admitted to the facility in January of 2025 with a diagnosis including, but not limited to, dementia.</p> <p>Review of a care plan dated 1/20/2025 revealed the resident has a potential for nutritional decline with an intervention including, but not limited to, weigh as ordered.</p> <p>Record review of hospital discharge paperwork dated 1/16/2025 revealed the resident weighed 179.1 pounds on 1/14/2025.</p> <p>Additional record review revealed the resident weighed 179.0 lbs. on re-admission to the facility on 1/16/2025.</p> <p>Record review revealed the following weights were obtained for Resident ID #23:</p> <ul style="list-style-type: none"> <li>- 1/16/2025: 179 lbs.</li> <li>- 2/6/2025: 163.8 lbs.</li> <li>- 4/3/2025: 161.8 lbs.</li> <li>- 5/2/2025: 154.6 lbs.</li> </ul> <p>Record review revealed the resident experienced an 8.5% (15.2 lbs.) severe weight loss in less than one month from 1/16/2025 to 2/6/2025.</p> <p>Record review revealed a progress note authored by Registered Dietitian (RD), Staff D which indicated that he had assessed the resident on 2/7/2025 following the above-mentioned severe weight loss. Further review of his note revealed that he believed the resident's weight of 179 lbs. obtained on 1/16/2025 was an error and did not implement any interventions.</p> <p>Additional record review failed to reveal evidence that the physician was notified of Resident ID #23's severe weight loss, as indicated per the facility's policy.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further record review revealed the resident continued to lose weight and had experienced an additional weight loss of 7.2 lbs. in one month, from 4/3/2025 to 5/2/2025, without the facility implementing any interventions.</p> <p>Additional record review revealed a progress note dated 5/5/2025, authored by Staff D, that states in part, Weight: 154.6 lbs (5/2/25). No significant 1 or 6 month change. Slightly below recent usual body weight range. Tolerating meals with good intake. Appears adequately nourished. Monitor for restart of scheduled supplement.</p> <p>During a surveyor interview with Staff D, on 5/8/2025 at 10:03 AM, he revealed that he assessed the resident on 2/7/2025 and did not implement any interventions at that time. He indicated that he felt s/he appeared adequately nourished and that the weight that was obtained on 1/16/2025 was an error. However, he was unable to provide evidence that Resident ID #23 was reweighed to verify the accuracy of the weight that was obtained on 1/16/2025, or to determine if interventions should have been implemented following the resident's documented severe weight loss on 2/6/2025. Additionally, he acknowledged he did not implement any interventions following his/her weight loss on 5/2/2025.</p> <p>B. Record review revealed Resident ID #17 was admitted to the facility in April of 2025 with a diagnosis including, but not limited to, type 2 diabetes.</p> <p>Record review of a care plan dated 4/14/2025 revealed the resident has the potential for a nutritional decline and a history of weight loss. Staff interventions include to obtain weights as ordered.</p> <p>Record review of a physician's order for Resident ID #17 dated 4/14/2025 revealed to obtain weekly weights every Monday for 4 weeks.</p> <p>Record review revealed the following weights were obtained for Resident ID #17:</p> <ul style="list-style-type: none"> <li>- 4/14/2025: 155.0 lbs.</li> <li>- 4/28/2025: 143.6 lbs.</li> <li>- 5/2/2025: 143.0 lbs.</li> <li>- 5/4/2025: 148.2 lbs.</li> <li>- 5/5/2025: 143.0 lbs.</li> </ul> <p>Record review revealed the resident experienced a 7.74% (12 lbs.) severe weight loss in less than one month from 4/14/2025 to 5/5/2025.</p> <p>Record review failed to reveal evidence that any interventions were implemented by the facility after the resident's 7.74% severe weight loss, in less than one month. Additional record review failed to reveal evidence that the physician was notified of the severe weight loss, per the facility's policy.</p> <p>2A. Record review failed to reveal evidence that Resident ID #23's weights were obtained weekly on 1/23/2025 and 1/30/2025 as indicated in the facility's policy.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Additional record review failed to reveal evidence that the facility reweighed the resident for a 5 lbs. weight discrepancy on 2/6/2025.</p> <p>B. Record review failed to reveal evidence that Resident ID #17's weight was obtained upon admission on [DATE], as indicated in the facility's policy. The first weight was obtained two days after admission, on 4/14/2025.</p> <p>Additional record review failed to reveal evidence that a weekly weight was obtained on 4/21/2025, as ordered.</p> <p>C. Record review revealed Resident ID #22 was admitted to the facility in June of 2021 with diagnoses including, but not limited to [NAME]-[NAME] disease (a rare progressive inherited neurodegenerative disorder that primarily affects the brain), adult failure to thrive and dysphagia (difficulty swallowing).</p> <p>Record review revealed the following weights were obtained for Resident ID #22:</p> <ul style="list-style-type: none"> <li>- 1/16/2025: 90.8 lbs.</li> <li>- 2/6/2025: 85.8 lbs.</li> <li>- 2/16/2025: 85.8 lbs.</li> <li>- 2/24/2025: 83.6 lbs.</li> <li>- 3/7/2025: 81.2 lbs.</li> <li>- 3/24/2025: 87.0 lbs.</li> </ul> <p>Record review revealed the resident experienced a weight loss of 5 lbs. (5.5%) on 2/6/2025 from the previous weight that was obtained on 1/16/2025. Record review failed to reveal evidence that the resident was reweighed after a 5 lbs. weight discrepancy was observed, until 2/16/2025, one month later.</p> <p>Record review revealed a physician's order dated 2/16/2025 for weekly weights x 4.</p> <p>Record review failed to reveal evidence that a weekly weight was obtained on 3/16/2025, as ordered.</p> <p>During a surveyor interview on 5/8/2025 at 1:33 PM with Registered Nurse, Staff B, she was unable to provide evidence of the above-mentioned missing weights.</p> <p>During surveyor interviews on 5/7/2025 at 1:18 PM and at 1:42 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that interventions had been implemented to address Resident ID #s 17 and 23's severe weight losses.</p> <p>Additionally, the DNS was unable to provide evidence that Resident ID #s 17, 22, and 23's weekly weights were obtained as ordered, or that the facility's Weight Monitoring policy was followed.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 2 of 2 medication carts observed.</p> <p>Findings are as follows:</p> <p>Review of a facility's policy titled Storage and Expiration Dating of Medications and Biologicals dated [DATE], states in part, .Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened .</p> <p>1a. During a surveyor observation on [DATE] at 9:40 AM of the Portside Unit medication cart, in the presence of Registered Nurse (RN), Staff A, revealed the following:</p> <ul style="list-style-type: none"> <li>- One Breo Ellipta Inhaler, opened with a date of 3/22. Review of the manufacturer's instructions indicate to discard the inhaler 6 weeks after opening.</li> </ul> <p>During a surveyor interview with Staff A immediately following the above observation, she acknowledged that the inhaler had a date of 3/22, and that the inhaler was expired.</p> <p>1b. During a surveyor observation on [DATE] at 8:57 AM of the Starboard Unit medication cart, in the presence of RN, Staff C, revealed the following:</p> <ul style="list-style-type: none"> <li>-One Treligy Ellipta inhaler, opened and not dated. Review of the manufacturer's instructions indicate to discard the inhaler 6 weeks after opening.</li> <li>-One Breyndra Inhaler, opened and not dated. Review of the manufacturer's instructions indicate to discard the inhaler 3 months after opening.</li> <li>-One Flovent inhaler, opened and not dated. Review of the facility policy indicates medications should be dated when opened.</li> <li>- One Fluticasone propionate nasal spray, opened and not dated. Review of the manufacturer's instructions indicate to discard the nasal spray after using 120 sprays.</li> <li>- Two Albuterol Inhalers, opened and not dated. Review of the facility policy indicates medications should be dated when opened.</li> </ul> <p>During a surveyor interview with Staff C immediately following the above observation, she acknowledged that the above-mentioned medications were opened and not dated.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview on [DATE] at approximately 4:00 PM with the Director of Nursing Services (DNS), she was unable to provide evidence the expired Breo Ellipta inhaler was not removed from the Portside Unit medication cart. Additionally, the DNS was unable to provide evidence the above-mentioned medications were dated when opened.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide a dietary menu that meets the nutritional needs of residents in accordance with established national guidelines.</p> <p>Findings are as follows:</p> <p>1. Record review of the facility's diet manual titled, Maryland Department of Health and Mental Hygiene Diet Manual for Long Term Care Residents 2014 Revision, failed to meet the current established national guidelines (the United States Department of Agriculture (USDA) establishes and reviews national guidelines every 5 years, to promote health, meet nutrient needs and provide guidance for healthy dietary patterns by life stages). The diet manual provided to the surveyor by the facility was from 2005 to 2010, indicating the guidelines were outdated as the current national guidelines were revised in 2020 with new recommendations.</p> <p>During a surveyor interview with Registered Dietitians, Staff D and E on 5/8/2025 at 10:03 AM, they revealed that the facility's menus are generated from corporate each month and each facility's dietitian is responsible for reviewing the menu for nutritional adequacy. Additionally, they indicated they use the Maryland Diet Manual, 2014 Revision as a standard to review menus each month.</p> <p>2. Record review of a document published by the USDA, revealed that a standardized recipe is utilized in a food service establishment to ensure the nutritional values per serving are valid and consistent, as the same products and quantities are being used every time the recipe is produced.</p> <p>Record review of the menu served from 5/4/2025 through 5/10/2025 failed to reveal evidence that standardized recipes were on file. Further record review revealed a binder titled, Apple Rehab Recipes Spring/Summer Menus 2016, containing several recipes from Allrecipes.com and other internet sources, which did not contain caloric or nutrient information.</p> <p>During a surveyor interview with the Food Service Director on 5/8/2025 at 11:50 AM, he revealed that he does not use standardized recipes when preparing meals for residents.</p> <p>During a surveyor interview via telephone with the Director of Nutrition Services on 5/8/2025 at 12:36 PM, she revealed that she would expect the dietitian at each facility to follow the company's diet manual, Maryland Department of Health and Mental Hygiene Diet Manual for Long Term Care Residents 2014 Revision, to review menus for nutritional adequacy. She was unaware that the facility's diet manual was out of date. Additionally, she indicated that standardized recipes are not used in the facility. Further, she was unable to provide evidence that the facility's menus met the nutritional needs of residents in accordance with established national guidelines.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that food is stored and distributed in accordance with professional standards for food service safety, relative to the main kitchen and 2 of 2 units observed during meal service.</p> <p>Findings are as follows:</p> <p>1. Record review of the United States (U.S.) Food and Drug Administration (FDA) Food Code, 2022 Edition, section 4-601.11 states in part, .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris .</p> <p>Record review of the U.S. FDA Food Code, 2022 Edition, Section 3-501.17 states in part, .READY -TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .</p> <p>During the initial tour of the main kitchen with the Food Service Director (FSD) on 5/5/2025 at 9:24 AM, the following was observed in the walk-in refrigerator:</p> <ul style="list-style-type: none"> <li>- One 46 ounce (oz.) bottle of nectar thickened orange juice, opened and not dated. Manufacturer's instructions indicate to use the product within 10 days once opened.</li> <li>- One 46 oz. bottle of nectar thickened apple juice, opened and dated 4/6. Manufacturer's instructions indicate to use the product within 10 days once opened.</li> </ul> <p>Additional observations of the main kitchen during the initial tour revealed the ceiling of the microwave had clumps of yellow food matter stuck to it.</p> <p>During a surveyor interview immediately following the above observations with the FSD, he acknowledged that the juices should be marked with the date they are opened and discarded after 10 days. Additionally, he acknowledged that the microwave had food debris inside.</p> <p>2. Record review of the U.S. FDA Food Code, 2022 Edition, section 3-301 states in part, .Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form .</p> <p>During a follow up visit to the kitchen during lunch preparation on 5/6/2025 at 11:47 AM, Cook, Staff F, was observed handling two slices of white bread and sliced cheese, assembling a sandwich without using gloves.</p> <p>During a surveyor interview with the FSD immediately following the observation, he acknowledged that Staff F should have been wearing gloves prior to handling food and discarded the sandwich.</p> <p>3. Record review of the U.S. FDA Food Code, 2022 Edition, section 3-307.11 states in part, .Food shall be protected from contamination .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During surveyor observations of the breakfast meal service on 5/6/2025 at 8:00 AM, a steam table cart was stationed at the beginning of the Portside Unit. Breakfast plates containing hot food were carried from the steam table to resident rooms, up to approximately 50 feet away.</p> <p>During surveyor observations of the lunch meal service on 5/7/2025 at 11:59 AM, a steam table cart was stationed adjacent to the clean linen closet on the Portside Unit. Uncovered lunch plates containing hot food were carried from the steam table to room [ROOM NUMBER] (the furthest resident room from the steam table) approximately 42 feet from the right, and to rooms approximately 37 feet away from the left by Dietary Aides, Staff L and M.</p> <p>During surveyor observations of the lunch meal service on 5/7/2025 at 12:45 PM, a steam table cart was stationed adjacent to room [ROOM NUMBER] on the Starboard Unit. Uncovered lunch plates containing hot food were carried from the steam table down to rooms approximately 68 feet down the hallway to room [ROOM NUMBER] (the furthest resident room from the steam table) by Staff L and M.</p> <p>During a surveyor interview with Staff L and M, immediately following the above observations, they acknowledged that they were carrying uncovered plates of hot food down the hall to serve residents. Additionally they revealed that plates of food are only covered if the residents aren't going to be eating their meals right away.</p> <p>During a surveyor interview with the FSD on 5/7/2025 at 12:57 PM, he indicated that carrying uncovered meals down the halls has been the facility's practice. He was unable to provide evidence that the meals were being protected from potential contamination.</p>