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	05/29/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to inform the resident's appointed representative, in advance, of the care to be furnished by the physician or other provider, of the risks and benefits of proposed care or treatment alternatives relative to the ordering of, and administration of, antipsychotic medications for 2 of 5 residents reviewed, Resident ID #s 25 and 35.Findings are as follows:1. Record review revealed Resident ID #25 was admitted to the facility in September of 2025 with diagnoses including, but not limited to, Alzheimer's disease, unspecified psychosis (a collection of symptoms that affect the mind, causing a temporary but profound loss of contact with reality) and major depressive disorder.Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating the resident has moderate cognitive impairment.Review of a care plan focus area dated 8/12/2025 revealed the resident is receiving psychotropic medications related to psychosis. Record review revealed the resident was prescribed and subsequently administered the following psychotropic medications:-Trazodone 25 milligrams (mg) daily with a start date of 3/26/2026-Valproic Acid 500 mg/10 milliliter (ml) give 15 ml twice a day with a start date of 4/14/2026-Rexulti 1 mg daily with a start date of 4/28/2026-Seroquel 150 mg daily at bedtime with a start date of 5/2/2026-Seroquel 75 mg twice daily with a start date of 5/2/2026-Lorazepam 0.5 ml three times a day with a start date of 5/13/2026Record review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident representative was informed of the risks and benefits, side effects, and/or treatment alternatives.2. Record review revealed Resident ID #35 was admitted to the facility in January of 2026 with diagnoses including, but not limited to, Alzheimer's disease, unspecified psychosis and anxiety disorder.Record review of a Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15 indicating the resident has moderate cognitive impairment.Review of a care plan focus area dated 5/11/2026 revealed the resident is receiving psychotropic medications related to psychosis, hallucinations, and delusions.Record review revealed the resident was prescribed and subsequently administered the following psychotropic medications:-Escitalopram Oxalate 10 mg daily with a start date of 3/10/2026-Trazodone 50 mg daily at bedtime with a start date of 4/13/2026 through 5/4/2026-Trazodone 50 mg twice a day with a start date of 5/4/2026 Record review failed to reveal evidence that the resident's representative was informed, in advance, of the addition of a new psychotropic medication to the resident's medication regimen or dosage increases to pre-existing psychotropic medications prior to initiating therapy. Additionally, record review failed to reveal evidence that the resident representative was informed of the risks and benefits, side effects, and/or treatment alternatives.During a surveyor interview on 5/28/2026 at 11:50 AM with the Staff Developer/Infection Preventionist, she acknowledged Resident ID #s 25 and 35 are receiving the above-mentioned psychotropic medications. Additionally, she was unable to provide evidence that the residents' representatives were informed in advance of psychotropic medications the residents were being administered, as required.During a surveyor (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 5/29/2026 at 9:31 AM with the Administrator, she was unable to provide evidence Resident ID #s 25 and 35's representatives were informed in advance of the psychotropic medications that were being administered to the residents, as required.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on clinical record review and staff interview, the facility failed to develop and implement a baseline care plan for each resident within 48 hours of a resident's admission, that includes the instructions needed to provide effective and person-centered care, including initial goals based on admission orders, for 1 of 1 resident reviewed who was newly admitted to the facility with a Prevena wound vac (a portable, disposable negative pressure therapy system designed to protect and manage surgical incisions by applying continuous suction to promote healing and reduce complications), Resident ID #54.Findings are as follows:Review of an undated facility policy titled Baseline Care Plans, states in part, A baseline care plan will be developed and implemented for each resident within 48 hours of admission in accordance with applicable regulatory requirements. The baseline care plan will include the minimum healthcare information necessary to provide appropriate care and services until the comprehensive care plan is completed. PROCEDURE.The interdisciplinary team will develop a baseline care plan within 48 hours of admission.The baseline care plan may include: Initial goals of care.Physician orders.Dietary orders.Therapy services.Social service needs.other immediate care needs and interventions.Record review revealed the resident was admitted to the facility in May of 2026 with diagnoses including, but not limited to, type 2 diabetes mellitus and viral hepatitis c.Record review failed to reveal evidence of a completed baseline care plan, initiated within 48 hours after admission, including initial goals based on admission orders.During a surveyor interview on 5/27/2026 at 12:05 PM, with Registered Nurse, Staff B, she revealed that the Minimum Data Set (MDS) Coordinator was responsible for completing resident care plans, and was unable to provide evidence of a completed baseline care plan, initiated within 48 hours after the resident's admission, stating, I don't know what you mean by baseline care plan.During a surveyor interview on 5/27/2026 at 12:26 PM, with the MDS Coordinator, she revealed that she is responsible for completing baseline care plans and indicated that they are completed on paper and kept in the resident's chart. She acknowledged that the resident's baseline care plan had not been completed 48 hours after his/her admission, per regulation and facility policy, as she was not at the facility when the resident was admitted and no other responsible party completed it.During a surveyor interview on 5/27/2026 at 12:42 PM, with the Staff Developer/Infection Preventionist, she revealed that she would expect baseline care plans to be completed 48 hours after the resident's admission, per regulation and facility policy.

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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 clinical record review and staff interview, the facility failed to meet professional standards of practice for 1 of 1 resident reviewed with a midline catheter (a type of intravenous catheter inserted into a vein in the upper arm often used to deliver antibiotics), Resident ID #59.Findings are as follows: Record review revealed the resident was admitted to the facility in May of 2026 with diagnoses including, but not limited to, sepsis due to enterococcus (an infection caused by bacteria entering the bloodstream requiring the use of intravenous antibiotics) and pneumonia.a. Record review revealed a physician's order dated 5/14/2026 to change the midline dressing on admission and once weekly, and as needed every night shift on Tuesday.Record review of the May 2026 Treatment Administration Record (TAR) revealed the above order was not signed off as completed on 5/14/2026.Additional record review failed to reveal evidence that the midline dressing change was completed as ordered on admission.b. Record review revealed a physician's order dated 5/19/2026 to measure external catheter length on admission, every 7 days with dressing changes and as needed every night shift on Tuesday.Record review of the May 2026 TAR revealed that it was signed off as completed on 5/19 and 5/26/2026. Additional record review failed to reveal evidence of documented measurements on the above mentioned dates and that measurements were completed on admission per the physician's order.c. Record review revealed a physician's order dated 5/19/2026 to measure upper arm circumference 6 inches above insertion site on admission, every 7 days with dressing changes and as needed every night shift on Tuesday.Record review of the May 2026 TAR revealed that it was signed off as completed on 5/19/2026 and 5/26/2026. Additional record review failed to reveal evidence of documented measurements on 5/26/2026 and that measurements were completed on admission per the physician's order.During a surveyor interview with Registered Nurse, Staff C on 5/29/2026 at 12:08 PM, she revealed that the measurements for the resident's midline catheter are done during third shift and signed off as completed in the TAR. Additionally, she was unable to locate where the arm circumference and external catheter length measurements were documented.During a surveyor interview with the Staff Developer/Infection Preventionist on 5/29/2026 at 12:19 PM, she was unable to provide evidence that the resident's midline external catheter length and his/her arm circumference were measured on admission and weekly per the physician's orders. Additionally, she was unable to provide evidence that the resident's dressing was changed on admission, as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on clinical record review, surveyor observation and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, relative to enhanced barrier precautions (EBP; refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities), for 1 of 1 resident reviewed with a Prevena wound vac (a portable, disposable negative pressure therapy system designed to protect and manage surgical incisions by applying continuous suction to promote healing and reduce complications), Resident ID #54.Findings are as follows:Review of a facility policy, last revised 5/5/2024, titled, Enhanced Barrier Precautions, states in part, It is the policy.to adhere to the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS) guidelines related to.EBP.to prevent the transmission of.MDROs.This facility will implement.EBP.during high-contact resident care activities for.indwelling medical devices. Examples of high-contact resident care activities: Dressing.Bathing/showering/providing hygiene.transferring.changing linens.changing briefs or assisting with toileting.device care or use.wound care.The facility will implement enhanced barrier precautions to include any resident with an indwelling device.regardless of MDRO colonization or infection status.Enhanced barrier precautions will remain in effect for the duration of the resident's stay at the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.Appropriate signage for EBP will be visible.Appropriate PPE [personal protective equipment] and hand sanitizer will be readily accessible for use.Record review revealed the resident was admitted to the facility in May of 2026 with diagnoses including, but not limited to, type 2 diabetes mellitus and viral hepatitis c. Further record review revealed the resident was admitted to the facility with a Prevena wound vac.Review of a physician's order dated 5/22/2026 states, [Right] hip-Wound drainage system-leave in place until follow up on 6/11. Do not remove dressing system. Monitor area for [signs and symptoms of] infection and report to [provider] as needed.Review of the May 2026 Treatment Administration Record revealed the above order was signed off each shift as completed.During surveyor observations on the following dates and times, EBP signage and appropriate PPE were not observed at the resident's doorway:5/26/2026 at 10:16 AM5/26/2026 at 11:47 AM5/27/2026 at 9:15 AM5/27/2026 at 11:05 AMDuring a surveyor interview on 5/27/2026 at 12:05 PM with Registered Nurse, Staff B, she revealed the resident was admitted with a wound vac and has a physician's order in place for the device and to monitor for signs and symptoms of infection. She further revealed that she monitors the device to ensure it is functioning, which includes checking the tubing and the dressing/surgical site.During a surveyor interview on 5/28/2026 at 9:00 AM, with the Infection Preventionist, she acknowledged that the resident was admitted to the facility with a wound vac and is not on EBP. She was unable to provide evidence why the resident was not placed on EBP and revealed that she is going to put the resident on EBP, after this concern was identified by the surveyor.