STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075044	A. Building B. Wing	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Farmington Valley	269 Farmington Ave Plainville, CT 06062

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42116 Based on observations, a review of the clinical record, staff interviews and a review of the facility policy, for 1 sampled resident (Resident #38) reviewed for choices, the facility failed to provide individualized assistance in accordance with their wishes and care plan. The findings include: Resident #38 was admitted to the facility on [DATE] with diagnoses that included cellulitis, falls, osteoarthritis, lumbar disc degeneration, morbid obesity, anxiety, chronic obstructive pulmonary disease, and muscle weakness. The care plan dated 12/15/19 identified, required assistance with all of his/her activities of daily living. Interventions directed to assist the Resident with application of his/her arm sling in the morning, grooming, dressing, mouth care and assistance with bathing activities. The care plan further directed that Resident #38 was awake at 5:00 AM and to have him/her up, washed and dressed by 7:30 AM. The admission Minimum Data Set (MDS) dated [DATE], identified intact cognition, required extensive assistance of 2 staff with bed mobility, transfers, dressing, toileting, personal hygiene and total dependence of 2 staff for bathing. Resident #38 required physical assistance of 2 staff while walking in his/her room and was identified as not steady and only able to stabilize with staff assistance. The MDS further identified Resident #38 did not require assistance with locomotion on and off the unit as he/she used an electric wheelchair. Resident #38's care card dated 1/27/20, identified Resident #38 received assistance of 2 NA's with care. The Resident's care card did not identified that Resident was to be up, washed and dressed by 7:30 AM as directed by the Resident's Care Plan. Observations on 2/24/20 at 9:40 AM, identified Resident #38 was sitting up in his/her wheelchair with a facility gown. Resident #38 was seen dressed after 10:00 AM. Observations on 2/26/20 at 6:26 AM and 9:15 AM identified the Resident was sitting up in his/her wheelchair with a facility gown and not dressed per the plan of care. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #38 on 2/26/20 at 9:15 AM, identified he/she woke this morning around 4:30 AM and per his/her wishes sleeps in the wheelchair. Resident #38 requested to the nursing staff since his/her arrival at the facility in December of 2019 that he/she wished to be dressed and washed prior to breakfast being served. Resident #38 identified this has not occurred since admission to the facility. Resident #38 identified he/she had continued to report his/her wishes to the nursing staff and NA's but nothing was done. An interview with LPN #1 on 2/26/20 at 9:20 AM, identified he/she was aware that Resident #38 woke up early in the morning, but Resident #38 does have to wait for his/her morning care until after breakfast was completed for the when 2 NA's were available to provide AM care for Resident #38. An interview with NA #2 on 2/26/20 at 10:39 AM, identified he/she would assist Resident #38 with dressing and personal care after breakfast was finished for the unit when a second NA was available to assist him/her. An interview with the Assistant Director of Nursing (ADNS) on 2/26/20 at 1:40 PM, identified Resident #38's care plan directed that the Resident wakes at 5:00 AM and wanted to be dressed in the morning before breakfast. The ADNS further identified the facility staff needed to accommodate the Resident's wishes as directed in his/her care plan. Review of facility policy for activities of daily living directed in part that the facility would provide individualized assistance to residents in preparation for daily activities, according to their wishes and plan of care. The resident's individual preferences and choices would be honored and included their morning routine.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on a review of the clinical record, a review of facility documentation, staff interviews, and a review of the facility policy for 1 of 3 residents reviewed for abuse (Resident #91), the facility failed to protect the resident from misappropriation of personal property. The findings include: Resident #91's diagnoses included major depressive disorder, dementia with behavioral disturbance, diabetes mellitus and schizoaffective disorder. The care plan dated 2/28/16 identified Resident #91 had a chronic/ progressive decline in intellectual functioning characterized by deficits in memory, judgment, decision making and thought process related to the dementia process. Interventions included to offer consistent daily routines and repeat communication by using more than one method (words, gestures, facial expression). A quarterly Minimum Data Set (MDS) dated [DATE] identified severe cognitive impairment and required extensive assistance with dressing, personal hygiene, bed mobility transfers between surfaces with assistance of one staff. A reportable event form dated 4/3/19 at 8:00 AM identified an allegation was made that a staff member may have been making phone calls from a resident phone line. A state of Connecticut mandated reporter form for long term care facilities dated 4/8/19 identified that a family member reported on 4/3/19 that there were phone charges on Resident #91's phone bill and they were not calls made by the resident. The state of Connecticut mandated reporter form for long term care facilities continued by indicating the Administrator identified the phone number in question belonged to a staff member. When the Administrator interviewed the staff member he/she admitted to using Resident #91's phone to call his/her own home. The staff member was suspended, then terminated, and the local law authorities were notified. Interview with the Administrator on 2/25/20 at 9:15 AM identified he received a phone call from Resident #91's family member that indicated she/he had received Resident #91's phone bill listing long distance calls that were not made by the Resident. Upon discovery by the Administrator that the phone number listed on Resident #91's phone bill matched one of the facility staff CNA#'s phone number, CNA #1 was interviewed and admitted to using Resident #91's phone to make personal phone calls. The Administrator further stated that there were a total of 18 calls placed for 88 minutes. CNA #1 was immediately terminated. Review of the abuse prohibition policy directed in part that each resident has the right to be free from abuse, mistreatment, neglect, exploitation and misappropriation of his or her personal property. The policy further directed that misappropriation of resident property was defined as the deliberate misplacement, exploitation or wrongful, temporary permanent use of a resident's belongings or money without the resident's consent.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on review of the clinical record, a review of facility documentation, staff interviews, and a review of the facility policy for 1 of 3 residents reviewed for abuse (Resident #91), the facility failed to provide evidence that a comprehensive investigation for misappropriation of a resident's personal property was conducted. The findings include: Resident #91's diagnoses include major depressive disorder, dementia with behavioral disturbance, diabetes mellitus and schizoaffective disorder. The care plan dated 2/28/16 identified a chronic/ progressive decline in intellectual functioning characterized by a deficit in memory, judgment, decision making and thought process related to the dementia process. Interventions included to offer consistent daily routines and repeat communication using more than one method (words, gestures, facial expression). A quarterly Minimum Data Set, dated dated dated [DATE] identified severe cognitive impairment and required extensive assistance with dressing, personal hygiene, bed mobility transfers between surfaces with assistance of with one staff. A reportable event form dated 4/3/19 at 8:00 AM identified an allegation was made that a staff member may have been making phone calls from a resident phone line. A state of Connecticut mandated reporter form for long term care facilities dated 4/8/19 identified a family member reported on 4/3/19 that there were phone charges on Resident #91's phone bill and they were not calls made by the resident. The state of Connecticut mandated reporter form for long term care facilities indicated the Administrator identified the phone number in question belonged to a staff member who when interviewed, admitted to using Resident #91's phone to call his/her own home. The staff member was suspended, terminated, and the local law authorities were notified. Interview with Administrator on 2/25/20 at 9:15 AM identified he received a phone call from Resident #91's family member indicating she/he had received Resident #91's phone bill that listed long distance calls that were not made by the Resident. The Administrator identified the phone number listed on Resident #91's phone bill matched one of the facility staff CNA's phone number. CNA #1 was interviewed and admitted to using Resident #91's phone to make personal phone calls. The Administrator further stated that there were a total if 18 calls placed for 88 minutes. Further interview with the facility Administrator indicated he/she was unable to produce investigative documents to provide evidence that a comprehensive investigation for misappropriation of a resident's personal property was conducted. Review of the abuse prohibition policy directed in part that the purpose of the policy was to ensure that each resident had the right to be free from abuse, mistreatment, neglect, exploitation and misappropriation of his or her personal property. The policy further directed documentation of the incident in the resident's nursing notes, and the Administrator, Director of Nursing or designees would immediately conduct an investigation that included interviews of all witnesses, including the person accused of abuse, interviews with all parties who may have knowledge useful to the investigation, any individuals requested by the accused, and to document the conclusion of the investigation.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on a review of the clinical record, staff interviews and a review of the facility policy, for one sampled resident reviewed for pain (Resident # 360), the facility failed to provide effective pain management. The findings include: Resident # 360 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis of spine with radiculopathy (pinched nerve) in the lumbar region, current breast cancer and contusions to the back and forearm. An admission evaluation dated 12/9/19 at 1:11 PM identified Resident #360 was alert, pleasant and cooperative. A physician's order dated 12/9/19 directed to assess pain every shift using the pain scale. Further orders directed Soma 350 milligrams (mg) every 6 hours as needed for muscle spasms and Hydrocodone 5 mg with Acetaminophen 325 mg every 6 hours as need for moderate to severe pain. A physician's progress note dated 12/10/19 identified Resident #360 had left lower spinal pain with radiation and a right upper extremity hematoma. A physician order dated 12/10/19 directed to provide ice to the resident's right hip and left lower extremity. This intervention was to be conducted every 15 minutes with ice on, and then 15 minutes without ice. The care plan dated 12/10/19 identified pain as a problem with interventions that included to provide medications as ordered, listen to my concerns/complaints about pain and observe for signs and symptoms of increased pain. A physician progress note dated 12/11/19 identified Resident #360 ambulates with the assistance of a rolling walk, an occupational therapy evaluation, and treatment 5 times a week for 4 weeks. A nursing progress note dated 12/14/19 at 10:57 AM identified Resident #360 called requesting to speak to the supervisor and demanding to go home secondary to poor pain management. The nursing progress note dated 12/14/19 at 10:57 AM indicated the nurse notified the APRN who ordered Robaxin (muscle relaxant) 500 mg every 6 hours until Soma (muscle relaxant) was available. The nursing progress further identified Resident #360 was also medicated with Hydrocodone 5 mg with Acetaminophen 325 mg (opioid pain reliever) and ice was applied as ordered. A physician order dated 12/14/19 at 11:00 AM directed to administer Robaxin 500 mg every 6 hours as needed for spasms until Soma was available. An additional physician's order dated 12/14/19 directed imaging of the pelvis and lower spine due to increased pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the December 2019 medication administration record (MAR) MAR dated 12/10/19 through 12/13/19 identified Resident #360's pain level during the day shift was documented between 6-8 out of a scale of 0 to 10 (10 being the highest level of pain), and on the evening shift from 12/11/19 through 12/13/19 Resident #360's pain was documented as 8. Soma was not administered from 12/10/19 through 12/13/19. Interview with RN #1 on 2/24/2020 1:00 PM identified Resident #360 reported low back pain and Hydrocodone 5 mg with Acetaminophen 325 mg provided some relief. Interview with RN #2 (day shift supervisor) on 2/25/19 at 10:00 AM identified she was called to see Resident #360 on 12/14/19 as the Resident wanted to be discharged due to inadequate pain management. RN #2 further identified Person #1 had contacted her that day informing her that Resident #360's pain management was ineffective and indicated the resident had been receiving Soma (muscle relaxant) prior to admission. RN #2 further identified that the Soma was ordered when Resident #360 was admitted but had not been administered. RN #2 indicated she proceeded to administer Soma to the resident and the medication was not in stock. RN #2 identified it was never delivered from the pharmacy although it was ordered on 12/9/19. The pharmacy indicated they never received the prescription, and the facility staff may not have recognized the medication as a controlled substance that required the physician or APRN to directly communicate the order to the pharmacy, and they did not. RN #2 identified education was provided to the staff after this incident that addressed effective pain management. Interview with Pharmacist #1 on 2/25/19 at 1:00 PM identified Resident #360's admission physician order sheet listed Soma 350 mg every 6 hours prn muscle spasms but a direct APRN/physician prescription was not received until 12/14/19. He further identified a controlled substance cannot be dispensed without a direct APRN/physician prescription therefore it was not delivered to the facility until 12/14/19 when the physician prescription was properly received. The facility provided education beginning in January 2020 to staff regarding notifying the prescriber for inadequate pain control. In addition, pain medication prescriptions need to be initiated upon admission, and that it is necessary that the APRN/MD call in the prescription for controlled substances. The facility policy entitled Pain Management directed in part that each Resident should be provided an optimal level of comfort. The physician should be notified if interventions are ineffective and work to develop new approaches that will alleviate discomfort for the Resident.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40173 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #94) reviewed for unnecessary medications, the facility failed to ensure a psychoactive as needed medication was ordered for fourteen days. The findings include: Resident #94 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbances, and anxiety. The care plan dated 11/4/19 identified Resident #94 had episodes of paranoia. Interventions included to administer medications as ordered. The quarterly Minimum Data Set (MDS) dated [DATE] identified severe cognitive impairment, delusions, wandering behaviors and received antipsychotic medications. A physician's order dated 1/31/20 directed the administration of Lorazepam 0.5 milligram (mg) by mouth once daily and as needed every 6 hours for anxiety through 2/4/20. A physician's order dated 2/10/20 directed to discontinue the administration of Lorazepam at 9:00 AM to Resident #94. APRN #2 note dated 2/13/20 identified Resident #94's Lorazepam had been discontinued secondary to excessive sedation and indicated the plan for Resident #94 was to renew Ativan 0.5 mg every 6 hours as needed for anxiety. A physician's order dated 2/13/20 directed administration of Lorazepam 0.5 mg by mouth to Resident #94 as needed every 6 hours for anxiety for 90 days. Interview and clinical record review with APRN #1 on 2/26/20 at 2:07 PM identified that she was the medical APRN caring for Resident #94. APRN #1 identified in the facility, the psychiatric APRN was not able to write orders for residents, but documented recommendations. APRN #1 followed the recommendations from APRN #2, the psychiatric APRN from the 2/13/20 notes as relayed by the nursing staff when writing an order for administration of Lorazepam 0.5 mg every 6 hours for 90 days. Interview with RN #4, the corporate nurse, on 2/26/20 at 3:20 PM noted medication orders for as needed psychotropic drugs are to be limited to 14 days unless the attending physician or prescribing practitioner believes it is appropriate for the order to be extended. The physician or practitioner must then document the rationale for prescribing the medication for longer than 14 days in the clinical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with APRN #2 on 2/27/20 at 8:33 AM identified he was the psychiatric APRN caring for Resident #94 and did so on a consultant basis. APRN #2 identified although he consulted on residents in the facility, he was not able to write orders for resident medications. APRN #2 identified he would write his recommendations in the clinical records, and he then relied on the APRN in the facility to write the actual medication orders for the residents. APRN #2 identified he was very familiar with regulations surrounding prescribing as needed psychoactive medications. APRN #2 identified although he wrote recommendations on 2/13/20 for Resident #94 to receive Lorazepam every 6 hours as needed for anxiety for 90 days, he expected the APRN who actually would write the order for the resident to be certain the order was written appropriately. The facility policy failed to have a policy that indicated psychoactive medications that are prescribed as needed cannot be ordered for longer than fourteen days.