| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075144 | A. Building<br>B. Wing | 08/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab Guilford | 10 Boston Post Rd<br>Guilford, CT 06437 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43127<br><br>Based on clinical record review, facility documentation review and interviews for 12 of 27 residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12) who were reviewed for medication administration, the facility failed to ensure the physician was notified timely when medication administration due at 9 and 10 PM on 7/23/2022 was not completed timely, in accordance with physician's orders, for twelve (12) residents (41 medications, including antiseizure meds, were omitted and a gastric tube feeding that was administered late). The findings include:<br><br>Review of the facility reportable event dated 7/25/2022 identified while the facility was reviewing nurse performance for the 7/23/2022 evening shift, it was noted that 12 residents lacked signatures from RN #1 on the Electronic Medication Administration Record (E-MAR) for the 9 PM medication administration. Facility investigation included an interview with RN #1, and RN #1 indicated, if she did not sign off the medications on the E-MAR, then she did not administer the medications. The Medical Director and all residents' responsible parties were updated, and RN #1 was removed from the schedule. All residents were assessed by their practitioner on 9/25/2022 with no ill effects noted.<br><br>Additional review of facility documentaiton failed to identify the physician was notified prior to 7/25/2022, two (2) days after the omited medications.<br><br>1. A review of Resident #1's clinical record identified that he/she had diagnoses that included pyothorax without fistula and COPD. The Resident Care Plan (RCP) dated 6/2/2022 identified Resident #1 required pain management for moderate to severe pain. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was alert and oriented and required opioid medication.<br><br>Resident #1's physician orders for Trazodone 100 milligrams (for anxiety) and Morphine Sulfate (analgesic) 20mg/ml = 0.25 ml (for moderate to severe pain) identified they were scheduled to be administered at 9:00 PM. Review of the E-MAR identified the Trazodone and Morphine Sulfate were not signed off in E-MAR to indicate they were administered.<br><br>2. Resident #2 had diagnoses that included Alzheimer's disease, cancer of the lung and bronchus, and polyneuropathy. The RCP dated 4/8/2022 identified Resident #1 took medications to help alleviate anxiety, depression, and adverse behaviors and that Resident #2 was at risk for pain or discomfort due to neuropathy. The quarterly MDS dated [DATE] identified that Resident #2 had severe cognitive impairment and required antidepressant medication.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Physician's orders for Aricept 10 mg (for dementia), Mirtazapine 15 mg (for depression), Senna (used for constipation) 8.6 mg and Namenda 10 mg (for Alzheimer's disease), for 9 PM and Acetaminophen 1000 mg identified they were scheduled to be administered at 10:00 PM. Review of the E-MAR identified the Aricept, Mirtazapine, Senna, Namenda and Acetaminophen were not signed off in E-MAR to indicate they were administered.<br><br>3. Resident #3 had diagnoses that included Parkinson's disease, psychotic disorder with delusions, and dementia with Lewy bodies. The RCP dated 4/13/2022 identified Resident #3 had history of psychotic behaviors including delusions or hallucination related diagnosis of depression and Parkinson's disease. The quarterly MDS dated [DATE] identified that Resident #3 had mild confusion, and received antipsychotic and antidepressant.<br><br>Review of physician orders for Aricept (treat dementia) 10 mg, Nuplazid 34 mg (antipsychotic), Senna Plus (for constipation) and Trazadone 25 mg (antidepressant) identified they were scheduled to be administered at 9:00 PM. Review of the E-MAR identified the Trazodone and Morphine Sulfate were not signed off in E-MAR to indicate they were administered.<br><br>4. Resident #4 had diagnoses that included Parkinson's disease, dementia, COPD, prostate cancer, osteoarthritis, and chronic pain. The RCP dated 5/12/2022 identified Resident #4 was at risk for respiratory distress and ineffective breathing patterns, and pain related to chronic pain syndrome disease. Interventions directed to administer medications per physician's orders. The Quarterly MDS dated [DATE] identified severe cognitive impairment with and Resident #4 received antidepressant and antipsychotic medications.<br><br>Review of physician orders identified Seroquel 25 mg (antipsychotic medications), Benztropine Mesylate 2 mg (Parkinson's medications), Carbidopa-Levodopa ER ,d+[DATE] mg (Parkinson ' s medication), Aricept 5 mg (treat dementia), Budesonide suspension 1 unit (nebulizer for pneumonia), Preformist nebulizer (for pneumonia), Genteal eye drops (lubricant eye drops), Flomax 0.4 (for prostate) were scheduled to be administered at 9:00 PM and Tylenol 1000 mg (for pain) was scheduled to be administered at 10 PM. Review of the E-MAR identified the medications were not signed to indicate they were administered.<br><br>5. Resident #5 had diagnoses that included anorexia, depression, and dementia. The Quarterly MDS dated [DATE] identified Resident #5 had mild to moderate cognitive impairment, had a feeding tube, received a portion of total calories through a tube feeding, and received antidepressant medications. The RCP dated 6/28/2022 identified Resident #5 had a feeding tube to help improve and maintaining nutritional status due to anorexia and failure to thrive (inability to maintain weight and nutritional status), was at risk for dehydration, and had depression. Interventions directed to administer feed, medications, and G-tube flushes as per physician's order.<br><br>Review of physician orders identified Resident #5 was scheduled to receive liquid nutritional supplement tube feeding at 75 milliliters per hour to start at 9:30 PM and stop at 5:30 AM. Review of the E-MAR identified the liquid supplement tube feeding was started at 11:30 PM (two hours after the scheduled time). Further review identified Resident #5 was scheduled to receive Aricept HCL 5 mg (for dementia), and Remeron F/C 15 mg (for depression) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Resident #6 had diagnoses that included convulsions (seizures), breast cancer, depression, and anxiety disorder. The RCP dated 6/10/2022 identified that Resident #6 had a seizure disorder and directed to administer medications as ordered. The Quarterly MDS assessment dated [DATE] identified Resident #6 had mild to moderate cognitive impairment with and received antidepressant and antianxiety medication.<br><br>Resident #6's physician orders identified Lamotrigine 150 mg (for seizures), and Clonazepam 0.5 mg (for anxiety) were scheduled to be administered at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>7. Resident #7 had diagnoses that included anxiety disorder and COPD. The RCP dated 5/7/2022 identified Resident #7 was at risk for respiratory compromise related to COPD and had anxiety or was restless at times. Interventions directed to administer medications as ordered. The Quarterly MDS dated [DATE] identified that Resident #7 had moderately impaired cognition and received antidepressant medications.<br><br>Review of physician orders identified Resident #7 was scheduled to receive Budesonide 0.5 mg (nebulizer breathing treatment) and Trazodone 50 (for anxiety) mg at 9 PM and they were not signed off in E-MAR to indicate they were administered.<br><br>8. Resident #8 had diagnoses that included low back pain, glaucoma, and anxiety disorder. The annual MDS assessment dated [DATE] identified Resident #8 had moderate cognitive and received antidepressant medication. The RCP dated 7/2/2022 identified Resident #8 was at risk for pain neuropathy (feeling like pins and needles in hands and feet) and had increased agitation at times. Interventions directed to administer medications as per physician ' s order.<br><br>Review of physician orders identified Resident #8 was scheduled to receive Travoprost eye drops (treat glaucoma), Trazodone 25 mg (for anxiety), and Gabapentin 100 mg (for neuropathic pain) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>9. Resident #9 had diagnoses that included vascular dementia, and prostate cancer. The quarterly MDS assessment dated [DATE] identified that Resident #9 had mild to moderate cognitive impairment and received antidepressant medication. The RCP dated 7/6/2022 identified Resident #9 had dementia and received medications to help alleviate anxiety. Interventions directed to administer medications per physician's order.<br><br>Review of physician orders identified Resident #9 was scheduled to receive Aricept 10 mg (for dementia) and Trazodone 25 mg (treat depression) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>10. Resident #10 had diagnoses that included dementia, delusional disorder, anxiety disorder and depression. The RCP dated 5/9/2022 identified Resident #10 had decline in memory, judgment, decision making and thought process due to delusional disorder and dementia. Interventions directed to administer medications per physician's order. The quarterly MDS assessment dated [DATE] identified Resident #10 had moderate cognitive impairment and received antipsychotic and antidepressant medication.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of physician orders identified Resident #10 was scheduled to receive Melatonin 3 mg (sleeping aide), Olanzapine 2.5 mg (for delusions), Trazodone 100 mg (treat depression), and Carboxy Methyl Cellulose eye drops (for dry eyes) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>11. Resident #11 had diagnoses that included Parkinson's disease, depression, low back pain, and polyneuropathy. The annual MDS assessment dated [DATE] identified Resident #10 had moderately impaired cognition and antipsychotic and antidepressant medications. The RCP dated 7/20/2022 identified Resident #11 had dementia, was at risk for pain, was unable to verbalize pain due to cognitive impairment and received scheduled mediations for neuropathy (pain). Interventions directed to administer medications as per physician's order.<br><br>Review of physician orders identified Resident #11 was scheduled to receive Trazodone 25 mg (treat depression), Gabapentin 100 mg (treat pain) and Phenelzine 30 mg (for depression) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>12. Resident #12 had diagnoses that included dementia, schizoaffective behavior, depression, and Hodgkin's lymphoma. The quarterly MDS dated [DATE] identified Resident #12 was alert and oriented and received antipsychotic and antidepressant medications.<br><br>Review of physician orders identified Resident #12 was scheduled to receive Zyprexa 25 mg and Lamotrigine 50 mg at 9 PM and they were not signed off in E-MAR to indicate they were administered.<br><br>Interview, clinical record review and facility documentation review with RN #1 on 8/11/2022 at 11:30 AM identified that she arrived at work approximately 4:30 PM and about 2 to 3 hours into her shift she started to feel ill. RN #1 indicated during the 9 PM medication administration pass she became ill and could not complete the medication pass for all the residents. RN #1 indicated she had given report and her keys to the 3 to 11 PM shift supervisor (RN #2) at approximately 9:30 PM, she notified the DON, and the DON came into work at approximately 10 PM (the DON sent RN #1 home). She further indicated that she had administered one narcotic to one resident during the 9 PM medication pass but did not sign that she had given the medication because she was ill.<br><br>Interview, clinical record review and facility documentation review with RN #2 on 8/11/2022 at 12:42 PM identified that he called the DNS at approximately 9:30 PM when he noticed that RN #1 was ill. He identified that he took the narcotic and medication cart keys from RN #1 and secured the medications. RN #2 further indicated that RN #1 may not have been able to complete the medication pass, and he gave the unit keys to the DON when the DON arrived at about 10 PM.<br><br>On 8/11/22 at 1:41 PM interview with RN #3 (oncoming nurse at 11 PM on 7/23/2022) identified on 7/23/2022 she received report from the DON and was not informed any residents did not receive their scheduled 9 PM and 10 PM medications.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview, clinical record review and facility documentation review with the DON on 8/11/2022 at 3:08 PM identified RN #1 had told her that she had not completed the medication administration. The DON indicated although the E-MAR shows resident names and medications due during the time frame (9 to 10 PM) and would also show a signature sign off if medications were already administered, she indicated that she could not determine what medications were given by RN #1 and she did not administer any of the medications without signatures on the E-MAR. The DON indicated although she drove RN #1 home due to illness, she did not ask RN #1 if the medications were administered; she indicated she was not sure if RN #1 would be a reliable source since she was not feeling well. The DON further identified although most of the residents could have been asked (9 out of 12 residents were alert and oriented or had mild/moderate cognition impairment), that she did not notify the physician prior to 7/25/2022 because she could not determine if the medications were administered or not.<br><br>The DON did not inquire or investigate if the medications that were not signed off on the E-MAR were given until 7/25/2022 (2 days later), and the physician was not notified.<br><br>Interview and clinical record reviews with the Medical Director (attending physician for the residents) on 8/11/2022 at 4:03 PM identified he was notified on 7/25/2022 of the incident on 7/23/2022 (2 days after the medications were not signed as administered), and on 7/25/2022 he performed exams for all the Residents who did not receive their scheduled medications. The Medical Directed indicated that he should have been updated at the time of incident on 7/23/2022 and he would have wanted to know to assess the residents if any adjustments were necessary to ensure the residents safety and continuity of care.<br><br>Twelve resident's medications were not administered timely, including antiseizure, antipsychotic, and antidepressant medications, and a gastric tube feeding was not administered timely. The physician was not notified until 7/25/2022, two (2) days after the incident.<br><br>A review of the facility Notification Policy dated October 2015, directed in part, the resident's physician should be made aware of any significant change in condition that may affect the resident's physical, mental, or emotional status. If the physician is not available, then the associate should be called.<br><br>A review of the undated facility Medication Error Policy directed in part, all medication errors will be reported to the physician. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43127<br><br>Based on clinical record review, facility documentation review and interviews for 12 of 27 residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12) reviewed for medication administration, the facility failed to ensure medications were administered in accordance with physician orders timely (41 medications, including antiseizure meds, were omitted and a gastric tube feeding that was administered late on 7/23/2022), and for nine observed residents, (Residents #14, #15, #16, #17, #18, #19, #20, #21, and #22) observed during medication administration, the facility failed to ensure medications administered timely. The findings include:<br><br>A).<br><br>Review of the facility reportable event dated 7/25/2022 identified while the facility was reviewing nurse performance for the 7/23/2022 evening shift, it was identified that 12 residents lacked signatures from RN #1 (charge nurse) on the Electronic Medication Administration Record (E-MAR) for the 9 PM medication administration, and indicated the scheduled medications were not administered. Facility investigation included an interview with RN #1, and RN #1 indicated if she did not sign off the medications on the E-MAR, then she did not administer the medications. The Medical Director and all residents responsible parties were updated, and RN #1 was removed from the schedule. All residents were assessed by their practitioner on 7/25/2022 with no ill effects noted.<br><br>1. A review of Resident #1's clinical record identified that he/ she had diagnoses that included pyothorax without fistula and COPD. The Resident Care Plan (RCP) dated 6/2/2022 identified Resident #1 required pain management for moderate to severe pain. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was alert and oriented and required opioid medication.<br><br>Resident #1's physician's orders for Trazodone 100 milligrams (for anxiety) and Morphine Sulfate (analgesic) 20mg/ml= 0.25 ml (for moderate to severe pain) identified they were scheduled to be administered at 9:00 PM. Review of the E-MAR identified the Trazodone and Morphine Sulfate were not signed off in E-MAR to indicate they were administered.<br><br>2. Resident #2 had diagnoses that included Alzheimer's disease, cancer of the lung and bronchus, and polyneuropathy. The RCP dated 4/8/2022 identified Resident #1 took medications to help alleviate anxiety, depression, and adverse behaviors and that Resident #2 was at risk for pain or discomfort due to neuropathy. The quarterly MDS dated [DATE] identified that Resident #2 had severe cognitive impairment and required antidepressant medication.<br><br>Physician orders for Aricept 10 mg (for dementia), Mirtazapine 15 mg (for depression), Senna (used for constipation) 8.6 mg and Namenda 10 mg (for Alzheimer ' s disease), for 9 PM and Acetaminophen 1000 mg identified they were scheduled to be administered at 10:00 PM. Review of the E-MAR identified the Aricept, Mirtazapine, Senna, Namenda and Acetaminophen were not signed off in E-MAR to indicate they were administered.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Resident #3 had diagnoses that included Parkinson ' s disease, psychotic disorder with delusions, and dementia with Lewy bodies. The RCP dated 4/13/2022 identified Resident #3 had history of psychotic behaviors including delusions or hallucination related diagnosis of depression and Parkinson's disease. The quarterly MDS dated [DATE] identified that Resident #3 had mild confusion, and received antipsychotic and antidepressant.<br><br>Review of Physician orders for Aricept (treat dementia) 10 mg, Nuplazid 34 mg (antipsychotic), Senna Plus (for constipation) and Trazadone 25 mg (antidepressant) identified they were scheduled to be administered at 9:00 PM. Review of the E-MAR identified the Trazodone and Morphine Sulfate were not signed off in E-MAR to indicate they were administered.<br><br>4. Resident #4 had diagnoses that included Parkinson's disease, dementia, COPD, prostate cancer, osteoarthritis, and chronic pain. The RCP dated 5/12/2022 identified Resident #4 was at risk for respiratory distress and ineffective breathing patterns, and pain related to chronic pain syndrome disease. Interventions directed to administer medications per physician orders. The Quarterly MDS dated [DATE] identified severe cognitive impairment with and Resident #4 received antidepressant and antipsychotic medications.<br><br>Review of physician orders identified Seroquel 25 mg (antipsychotic medications), Benztropine Mesylate 2 mg (Parkinson's medications), Carbidopa-Levodopa ER ,d+[DATE] mg (Parkinson's medication), Aricept 5 mg (treat dementia), Budesonide suspension 1 unit (nebulizer for pneumonia), Preformist nebulizer (for pneumonia), Genteal eye drops (lubricant eye drops), Flomax 0.4 (for prostate) were scheduled to be administered at 9:00 PM and Tylenol 1000 mg (for pain) was scheduled to be administered at 10 PM. Review of the E-MAR identified the medications were not signed to indicate they were administered.<br><br>5. Resident #5 had diagnoses that included anorexia, depression, and dementia. The Quarterly MDS dated [DATE] identified Resident #5 had mild to moderate cognitive impairment, had a feeding tube, received a portion of total calories through a tube feeding, and received antidepressant medications. The RCP dated 6/28/2022 identified Resident #5 had a feeding tube to help improve and maintaining nutritional status due to anorexia and failure to thrive (inability to maintain weight and nutritional status), was at risk for dehydration, and had depression. Interventions directed to administer feed, medications, and G-tube flushes as per physician's order.<br><br>Review of physician orders identified Resident #5 was scheduled to receive liquid nutritional supplement tube feeding at 75 milliliters per hour to start at 9:30 PM and stop at 5:30 AM. Review of the E-MAR identified the liquid supplement tube feeding was started at 11:30 PM (two hours after the scheduled time). Further review identified Resident #5 was scheduled to receive Aricept HCL 5 mg (for dementia) , and Remeron F/C 15 mg (for depression) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>6. Resident #6 had diagnoses that included convulsions (seizures), breast cancer, depression, and anxiety disorder. The RCP dated 6/10/2022 identified that Resident #6 had a seizure disorder and directed to administer medications as ordered. The Quarterly MDS dated [DATE] identified Resident #6 had mild to moderate cognitive impairment with and received antidepressant and antianxiety medication.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #6's physician orders identified Lamotrigine 150 mg (for seizures), and Clonazepam 0.5 mg (for anxiety) were scheduled to be administered at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>7. Resident #7 had diagnoses that included anxiety disorder and COPD. The RCP dated 5/7/2022 identified Resident #7 was at risk for respiratory compromise related to COPD and had anxiety or was restless at times. Interventions directed to administer medications as ordered. The Quarterly MDS dated [DATE] identified that Resident #7 had moderately impaired cognition and received antidepressant medications.<br><br>Review of physician orders identified Resident #7 was scheduled to receive Budesonide 0.5 mg (nebulizer breathing treatment) and Trazodone 50 (for anxiety) mg at 9 PM and they were not signed off in E-MAR to indicate they were administered.<br><br>8. Resident #8 had diagnoses that included low back pain, glaucoma, and anxiety disorder. The annual MDS dated [DATE] identified Resident #8 had moderate cognitive and received antidepressant medication. The RCP dated 7/2/2022 identified Resident #8 was at risk for pain neuropathy (feeling like pins and needles in hands and feet) and had increased agitation at times. Interventions directed to administer medications as per physician's order.<br><br>Review of physician orders identified Resident #8 was scheduled to receive Travoprost eye drops (treat glaucoma), Trazodone 25 mg (for anxiety), and Gabapentin 100 mg (for neuropathic pain) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>9. Resident #9 had diagnoses that included vascular dementia, and prostate cancer. The quarterly MDS dated [DATE] identified that Resident #9 had mild to moderate cognitive impairment and received antidepressant medication. The RCP dated 7/6/2022 identified Resident #9 had dementia and received medications to help alleviate anxiety. Interventions directed to administer medications per physician's order.<br><br>Review of physician orders identified Resident #9 was scheduled to receive Aricept 10 mg (for dementia) and Trazodone 25 mg (treat depression) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>10. Resident #10 had diagnoses that included dementia, delusional disorder, anxiety disorder and depression. The RCP dated 5/9/2022 identified Resident #10 had decline in memory, judgment, decision making and thought process due to delusional disorder and dementia. Interventions directed to administer medications per physician's order. The quarterly MDS dated [DATE] identified Resident #10 had moderate cognitive impairment and received antipsychotic and antidepressant medication.<br><br>Review of physician's orders identified Resident #10 was scheduled to receive Melatonin 3 mg (sleeping aide), Olanzapine 2.5 mg (for delusions), Trazodone 100 mg (treat depression), and Carboxy Methyl Cellulose eye drops (for dry eyes) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 11. Resident #11 had diagnoses that included Parkinson's disease, depression, low back pain, and polyneuropathy. The annual MDS dated [DATE] identified Resident #10 had moderately impaired cognition and antipsychotic and antidepressant medications. The RCP dated 7/20/2022 identified Resident #11 had dementia, was at risk for pain, was unable to verbalize pain due to cognitive impairment and received scheduled mediations for neuropathy (pain). Interventions directed to administer medications as per physician's order.<br><br>Review of physician orders identified Resident #11 was scheduled to receive Trazodone 25 mg (treat depression), Gabapentin 100 mg (treat pain) and Phenelzine 30 mg (for depression) at 9 PM and were not signed off in E-MAR to indicate they were administered.<br><br>12. Resident #12 had diagnoses that included dementia, schizoaffective behavior, depression, and Hodgkin's lymphoma. The quarterly MDS dated [DATE] identified Resident #12 was alert and oriented and received antipsychotic and antidepressant medications.<br><br>Review of physician orders identified Resident #12 was scheduled to receive Zyprexa 25 mg and Lamotrigine 50 mg at 9 PM and they were not signed off in E-MAR to indicate they were administered.<br><br>Interview, clinical record review and facility documentation review with RN #1 on 8/11/2022 at 11:30 AM identified on 7/23/2022 during the 9 PM medication administration pass she became ill and could not complete the medication pass for all the residents. RN #1 indicated she had given report and her keys to the 3 to 11 PM shift supervisor (RN #2) at approximately 9:30 PM. She notified the DON, and the DON came into work at approximately 10 PM (the DON sent RN #1 home). She further indicated that she had administered one narcotic to one resident during the 9 PM medication pass but did not sign the E-MAR to indicate she had given the medication because she was ill.<br><br>Interview, clinical record review and facility documentation review with RN #2 on 8/11/2022 at 12:42 PM identified that he called the DNS at approximately 9:30 PM when he noticed that RN #1 was ill. He identified that he took the narcotic and medication cart keys from RN #1 and secured the medications. RN #2 further indicated that RN #1 may not have been able to complete the medication pass, and he gave the unit keys to the DON when the DON arrived at the facility about 10 PM.<br><br>On 8/11/22 at 1:41 PM interview with RN #3 (oncoming nurse at 11 PM on 7/23/2022) identified there was no discrepancy with the narcotic count, and while doing her usual tour of the unit following report, she noticed the gastric feeding (G-tube feeding) for Resident #5 was not hung (ordered to start at 9:30 PM). She checked the E-MAR, saw that it was not signed off (indicated not started) and initiated the feeding at approximately 11:30 PM. RN #3 further indicated she received report from the DON and was not informed any residents did not receive their scheduled 9 PM and 10 PM medications, which resulted in no additional monitoring for safety and adverse effect, for the 12 residents who had medications omited.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075144 | A. Building<br>B. Wing | 08/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Rehab Guilford | 10 Boston Post Rd<br>Guilford, CT 06437 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview, clinical record review and facility documentation review with the DON on 8/11/2022 at 3:08 PM identified RN #1 had told her that she had not completed the medication administration. The DON indicated although the E-MAR shows resident names and medications due during the time frame (9 to 10 PM) and would also show a signature sign off if medications were already administered, she indicated that she could not determine what medications were given by RN #1 and she did not administer any of the medications without signatures on the E-MAR. The DON indicated although she drove RN #1 home due to illness, she did not ask RN #1 if the medications were administered; she indicated she was not sure if RN #1 would be a reliable source since she was not feeling well. The DON further identified although most of the residents could have been asked (9 out of 12 residents were alert and oriented or had mild/moderate cognition impairment), that she did not notify the physician prior to 7/25/2022 because she could not determine if the medications were administered or not.<br><br>The DON did not inquire or investigate if the medications that were not signed off on the E-MAR were given until 7/25/2022 (2 days later).<br><br>Twelve resident's medications were not administered timely, including antiseizure, antipsychotic, and antidepressant medications, and a gastric tube feeding was not administered timely.<br><br>Review of the facility General Dose Preparation and Medication Administration Policy, dated 12/1/2007, directed in part, to document medication administration when a medication is administered, and to administer medications within the time frame specified.<br><br>B).<br><br>Observations on 8/22/2022 at 10:20 AM identified LPN #8 was passing resident medications. Interview and review of the resident's Medication Administration Records (MARs) identified the following medications were scheduled and were not yet administered:<br><br>1. Resident #14's physician orders directed to administer Carvedilol 12.5 milligrams (mg) (reduce high blood pressure) by mouth at 9:00 AM.<br><br>2. Resident #15's physician orders directed to administer Clonazepam (antianxiety) 0.5 mg and Gabapentin 300 mg (nerve pain reliever) by mouth at 9:00 AM.<br><br>3. Resident #16's physician orders directed to administer Dorzolamide HCL ophthalmic solution 2% (to treat glaucoma reduce eye pressure) at 9:00 A.M.<br><br>4. Resident #17's physician orders directed to administer Levothyroxine 88 mcg by mouth (low thyroid) at 8:00 AM.<br><br>5. Resident #18's physician orders directed to administer Gabapentin 900 mg (nerve pain reliever) by mouth at 9 AM.<br><br>6. Resident #19's physician orders directed to administer Simethicone 80 mg (relieve gas symptoms) by mouth at 8:30 AM and was scheduled to receive Baclofen 5 mg (pain medication), DDAVP 0.4 mg (reduce amount of urine), Apixaban 5 mg (blood thinner), levetiracetam 500 mg (used to treat seizure disorder), Famotidine 20 mg (decrease stomach acid), Gabapentin 1,200 mg, Lithium Carbonate 150 mg (mood stabilizer) by mouth at 9:00 AM.<br><br>(continued on next page) |

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| | 075144 | A. Building<br>B. Wing | 08/11/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Apple Rehab Guilford | 10 Boston Post Rd<br>Guilford, CT 06437 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 7. Resident #20's physician orders directed to administer Baclofen 5mg, Alprazolam 0.5 mg (reduce anxiety), divalproex sodium 250 mg (used to treat seizure disorder) by mouth at 9:00 AM.<br><br>8. Resident #21's physician orders directed to administer Carvedilol 12.5mg (blood pressure control), Eliquis 5 mg (blood thinner), and Enalapril Maleate 20 mg (reduce blood pressure) by mouth at 9:00 AM.<br><br>9. Resident #22's physician orders directed to administer Memantine HCL 10 mg (slow progression of dementia symptoms) and Lopressor 50 mg (reduce blood pressure) by mouth at 9:00 AM.<br><br>Continued interview with LPN #8 identified the listed medications were due to be administered at 9 AM, and they would be considered late if they were administered after 10 AM. She further indicated she was unfamiliar with the residents on the unit and many residents had multiple medications which caused her to be late. LPN #8 indicated she notified her supervisor, and another nurse was helping to complete the remaining medications.<br><br>An interview with the DON on 8/22/2022 at 3:00 PM identified that scheduled medications should be given as ordered by the physician within the specified time frames for medications, and if a nurse was unable to complete medication administration timely they should ask for help. The DON further indicated that medications should be administered within one hour after the scheduled time to ensure residents receive their medications on time.<br><br>No facility policy was provided during survey for surveyor review. |

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| | 075144 | A. Building<br>B. Wing | 08/11/2022 |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>42117<br><br>Based on facility documentation review and interviews for facility Administration review, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care timely to include staff competencies and annual review of emergency manuals. The findings include:<br><br>1. Interview and facility documentation review with RN #9 on 8/22/2022 at 12:50 PM identified staff competencies had not been completed, and indicated she planned to start competencies in September 2022. RN #9 was unable to provide documentation of any staff competencies completed.<br><br>Interview with Corporate RN #1 on 8/22/2022 at 1:55 PM identified staff competencies should be completed yearly and she was aware some competencies were not completed. Interview identified although staff competencies were completed for hand hygiene and PPE use, RN #1 was unable to provide documentation that additional staff competencies were completed.<br><br>Interview with the Administrator on 8/22/2022 at 2:49 PM indicated the staff development RN was responsible for completion of staff competencies and he was not aware if they were current.<br><br>Interview with the DNS on 8/22/22 at 3:03 PM indicated she had worked at the facility for a year and a half, staff competencies should be completed yearly, and staff competencies were not completed in the prior 18 months (since she had started). The DNS did not know why they were not completed.<br><br>No facility policy was provided for surveyor review.<br><br>2. Review of the facility Emergency and Hazard Manual identified the last review was dated and signed by the Medical Director on 10/15/2019. Additional review identified the Manual was reviewed and signed by the Administrator, DON, and Maintenance Director 9/19/2019.<br><br>Interview and facility documentation review with the Administrator on 8/22/2022 at 1:40 PM identified the Manual should be reviewed, signed, and dated to indicate the review every year. The Administrator further identified the Emergency Management, facility Hazards Assessment, and facility Assessment Policy manuals had undated signature sheets that were signed by staff, and indicated he did not know why the signature pages were undated.<br><br>Interview and facility documentation review with the Administrator on 8/22/2022 at 3:20 PM identified if the Manuals were reviewed in QAPI, it would be included in the minutes. Review of the minutes dated 1/4, 4/5 and 8/4/2022 failed to identify a review of the Manuals were completed.<br><br>No facility policy was provided for surveyor review. |