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	11/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, facility documentation, facility policies, and interviews for one of nine residents (Resident #1) reviewed for accidents, the facility failed to provide adequate supervision to prevent a resident from obtaining a restricted dietary food item per their dietary orders, from the nursing units refrigerator. The failure resulted in a choking event. The findings include: Resident #1's diagnoses included Parkinson's disease, dementia, dysphagia, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of eleven out of fifteen (11/15), indicative of moderate cognitive impairment, had behaviors directed toward others (hitting, kicking, pushing) and rejection of care one (1) to three (3) of the prior seven (7) days, required supervision for mobility with a manual wheelchair, had the ability to self-propel in the wheelchair at least 150 feet in the corridor, and required a mechanically altered diet (change in texture of food or liquids). The Resident Care Plan dated 9/30/2025 identified impaired decision makings skills related to dementia, at risk for complications related to dysphagia, and required a mechanically altered diet. Interventions directed offer one step directions at a time, and provide diet as ordered, provide minced and moist diet and set up for meals with assist as needed, and watch for increased difficulty swallowing, holding food in mouth, increased drooling and food spillage. Nursing note dated 9/17/2025 at 5:37 AM identified Resident #1 was up around 5 AM and wondering in other resident's room to look for food, a sandwich, chips, soda, and crackers were given to him/her. He/she was put in a wheelchair in front of nurses station. Resident got up and tried to run away, nurse reoriented resident back to chair. Nursing note dated 9/17/2025 at 8:41 PM, written by LPN #1, identified Resident #1 was seen going into nursing unit's fridge. Nursing note dated 9/19/2025 at 10:58 PM, written by LPN #1, identified Resident #1 was seen going into nursing unit's fridge multiple times, sandwich offered. Physician orders dated 10/1/2025 directed regular diet, dysphagia/level 2 texture, and thin liquids consistency. Allow IDDSI (International Dysphagia Diet Standardization Initiative) level 5 (minced and moist). Resident #1 requires set-up assistance, provide inner lip plate and Kennedy cup, and directed Resident #1 requires supervision for diet. The Facility Reported Incident Form and Investigation dated 10/6/2025 at 7:15 AM identified Resident #1 was observed by staff holding his/her throat and was not able to verbally respond. The Heimlich maneuver was performed and Resident #1 cleared food from the passageway/expelled food. Additional information identified Resident #1 stated he/she obtained a sandwich from the refrigerator without staff assistance, and the sandwich was regular consistency. A nursing note dated 10/06/2025 at 9:41 PM by LPN #1 identified she observed Resident #1 holding throat area and look panicked. Resident #1 was asked if he/she is okay with no response. LPN #1 immediately performed the Heimlich maneuver to clear airway of turkey meat and was successful, and Resident #1 was back to baseline with stable vital signs. Resident #1 in bed resting for remainder of shift. Observation and interview with the DON at 10:15 AM of Resident #1's nursing unit on 10/8/2025 at identified a kitchenette area with a refrigerator located on the side of the unit hallway in an open alcove, available to all residents/staff/visitors. The alcove had a counter area with two (2) double cabinets under the counter, a microwave on the wall, and a sink. To the right of the cabinet/counters there was a full-size refrigerator/freezer. The DON stated the refrigerator was stocked daily by dietary staff with snacks and sandwiches for the evening and night shift. At the time of the observation, a lock was noted in place on the refrigerator. The DON stated the lock was a new intervention after Resident #1's choking event. Interview with LPN #1 on 10/8/2025 at 1:00 PM identified on 10/6/2025 during the 3:00 PM to 11:00 PM shift, LPN #1 had noted Resident #1 was in his/her wheelchair and had a sandwich in his/her possession. LPN #1 stated as she went to intervene, Resident #1 was noted to be not responsive toward LPN #1. The Heimlich maneuver was immediately initiated and LPN #1 called out for immediate assistance. Resident #1 successfully cleared what appeared to be turkey meat after the Heimlich maneuver. LPN #1 stated she was aware that in the past Resident #1 had opened the refrigerator door, but had not taken any food out. LPN #1 stated Resident #1 required supervision when out of bed to his/her wheelchair, and required an assist of one person if utilizing a walker. LPN #indicated the refrigerator was mainly utilized by the nursing staff, but it can also be accessed by family if they want to store any food for residents. LPN #1 stated the refrigerator stores mostly snacks and sandwiches for the residents. Interview identified Resident #1 was not observed until after he/she had accessed the sandwich and had taken at least one (1) bite of the sandwich without staff supervision. Interview with the DON, ADON, RN #1, RN #2, and Administrator on