STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075070	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Saybrook	1775 Boston Post Rd Old Saybrook, CT 06475

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of four (4) residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from mistreatment. The findings include:1. Resident #1's diagnoses included Wernicke's encephalopathy (a neurological condition that causes confusion, eye movement abnormalities and gait abnormalities), a history of alcohol dependence, and atrial fibrillation (an irregular heart rate). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of nine (9) indicative of moderately impaired cognition and was independent with bed mobility, transfers and ambulation. The Resident Care Plan (RCP) dated 6/12/2025 identified that Resident #1 had behavior issues including a history of a resident-to-resident altercation with a previous roommate (on 5/31/2025 Resident #1 grabbed his/her roommate's shirt and verbally threatened the roommate). Interventions directed to explain the importance of seeking staff assistance with solving issues with other residents rather than engaging in assaultive behavior, observe for signs of irritability and difficulties with other residents, provide support to manage potentially stressful encounters with others, psychiatric consults per physician's orders, and social service support as needed. Facility incident report dated 5/31/2025 at 12:00 AM identified Resident #1 was irritated that his/her roommate was making noise and grabbed the roommate by the shirt. Facility summary dated 6/10/2025 identified Resident #1 was placed in a private room. A nursing note dated 6/30/2025 at 3:15 PM written by RN #2, identified NA #1 reported that over the weekend she heard Resident #1 making a statement that was concerning to her. Advanced Practice Registered Nurse (APRN) #1 was notified and ordered a psychiatric consult. Telehealth psychiatric consult was scheduled for 5:00 PM, and Resident #1 was placed in the lounge area with staff. A psychiatric APRN note dated 6/30/2025 identified that a telehealth visit was completed and Resident #1 was deemed not a danger to him/herself or others, and staff observation was no longer necessary. Interview with NA #2 on 7/21/2025 at 1:05 PM identified that on 6/28/2025 (Saturday) she was in the dining room when she heard Resident #1 stating to a female resident in a threatening tone that he/she was going to be out of here soon because he/she was going to choke someone. 2. Resident #2 had diagnoses which included dementia without behavioral disturbances, mood disorder and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had impaired short-term and long-term memory, severely impaired cognition and was dependent on staff for both bed mobility and transfers. The RCP dated 6/27/2025 identified dementia and restless, agitated behaviors. Interventions directed to allow time to communicate, flexible routine, medications as ordered, and psychiatric/social services follow up. Review of the facility Reportable Event (RE) dated 7/1/2025 at 12:30 AM identified NA #1 witnessed Resident #1 drag Resident #2 out of their shared room by the resident's left arm, and was observed throwing Resident #2 into the hallway. Resident #2 was observed holding his/her left shoulder and was noted with facial grimacing; the police were notified, the family was notified, the APRN was notified, and a new order was obtained to transfer Resident #2 to the hospital for evaluation. The RE identified that upon readmission, Resident #2 was noted with a skin tear to the left shoulder, bruising to the right wrist and appeared comfortable. Resident rooms were changed, and Resident #1 had no roommate. Hospital physical exam note dated 7/1/2025 identified no acute distress, and superficial (only at the surface area, lacking depth) abrasions (scrape) were noted to the right anterior (front) knee and right medial (towards the midline) ankle. No pain with range of motion and Resident #2 was able to bear weight on the legs. The family declined imaging and Resident #2 was discharged back to the facility. Interview and record review with RN #1 on 7/21/2025 at 12:16 PM identified that she was at the nurse's station with NA #1 on 7/1/2025 at 12:30 AM when she heard a loud noise followed by a resident yelling. RN #1 and NA #1 then observed Resident #1 dragging Resident #2 across the floor by his/her arm and throwing him/her into the hallway in front of their shared room, and Resident #1 returned to the room and closed the room door. RN #1 indicated after Resident #1's incident with a roommate on 5/31/2025, Resident #1 was moved into a private room, and then was moved back into his/her original room when the roommate was discharged . RN #1 indicated a new roommate was admitted into Resident #1's room a few days prior to this incident. Record review identified Resident #2 was admitted into Resident #1's room on 6/26/2025. Interview with RN #4 and review of statement on 7/21/2025 at 2:38 PM identified on 7/1/2025 when she asked Resident #1 what happened, he/she indicated Resident #2 wouldn't shut up and he/she was sick of it. When

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of four (4) residents (Resident #2) reviewed for abuse, the facility failed to ensure staff acted on a report of a verbal threat timely, and failed to ensure the State Agency was notified timely after the facility was aware of an allegation. The findings include:Resident #1's diagnoses included Wernicke's encephalopathy (a neurological condition that causes confusion, eye movement abnormalities and gait abnormalities), a history of alcohol dependence, and atrial fibrillation (an irregular heart rate). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of nine (9) indicative of moderately impaired cognition and was independent with bed mobility, transfers and ambulation. The Resident Care Plan (RCP) dated 6/12/2025 identified that Resident #1 had behavior issues including a history of a resident-to-resident altercation with a previous roommate (on 5/31/2025 Resident #1 grabbed his/her roommate's shirt and verbally threatened the roommate). Interventions directed to explain the importance of seeking staff assistance with solving issues with other residents rather than engaging in assaultive behavior, observe for signs of irritability and difficulties with other residents, provide support to manage potentially stressful encounters with others, psychiatric consults per physician's orders, and social service support as needed. Review of nurse's notes from 6/28 and 6/29/2025 failed to identify Resident #1 exhibited any behaviors. A nursing note dated 6/30/2025 at 3:15 PM written by RN #2, identified that NA #1 reported that over the weekend she heard Resident #1 make a statement that was concerning to her. Advanced Practice Registered Nurse (APRN) #1 was notified and ordered a psychiatric consult. Telehealth psychiatric consult was scheduled for 5:00 PM, and Resident #1 was placed in the lounge area with staff. A psychiatric APRN note dated 6/30/2025 identified that a telehealth visit was completed and Resident #1 was deemed not a danger to him/herself or others, and staff observation was no longer necessary. Review of the State Agency Reportable Events website failed to identify the State Agency was notified of the verbal allegation that was noted on 6/30/2025. An interview with RN #2/nursing supervisor on 7/21/2025 at 12:48 PM identified on 6/30/2025 (Monday), NA #2 reported that over the weekend she had heard Resident #1 say that he/she was going to strangle someone in the dining room. RN #2 indicated she did not know why the allegation was not reported when it occurred. Interview with NA #2 on 7/21/2025 at 1:05 PM identified on 6/28/2025 (Saturday) she was in the dining room when she heard Resident #1 stating to a female resident that he/she was going to be out of here soon because he/she was going to choke someone. NA #2 indicated Resident #1 made the comment in a threatening tone and she knew the resident had a history of assaulting another resident, so she reported the incident to RN #3/nursing supervisor immediately. NA #2 further indicated RN #3 dismissed her and didn't go to see the resident. NA #2 stated she notified RN #3 again on 6/29/2025 (Sunday) but that he again dismissed her and didn't go to talk with the resident, so she then reported it on 6/30/2025 to RN #2. Interview with RN #3 on 7/21/2025 at 1:26 PM identified that he did not recall NA #2 notified him on 6/28 and 6/29/2025 that Resident #1 had threatened to choke someone. Although attempted, an interview with DNS #2 (previous DNS) was not obtained during the survey. Interview with the Administrator on 7/21/2025 at 12:34 PM identified that although she was notified on 6/30/2025 that Resident #1 threatened to choke someone, she did not act on the allegation because the comment was not directed at any specific resident. The Administrator indicated the allegation was not investigated; she indicated she was unable to locate an incident report and believed it was not completed and indicated the State Agency was not notified of the incident. Interview identified RN #3 should have acted on the reported threat when it was reported on 6/28 and 6/29/2025 and failed to identify staff did not notify administration when it was reported. Further, interview identified when the allegation was reported on 6/30/2025, the facility should have completed an incident report with an investigation and should have notified the State Agency. Review of the facility undated Abuse Policy directed in part, any staff member witnessing or suspecting abuse must immediately report it to a supervisor who should then immediately notify the DNS and the Administrator. An A & I (accident & incident) report will be completed for each resident involved. The DNS or designee will notify the resident's family, physician, DPH and local police as needed. The Administrator/DNS or designee will initiate an investigation and submit an online report to FLIS within two hours of notification.

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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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of four (4) residents (Resident #2) reviewed for abuse, the facility failed to ensure a verbal threat/allegation of mistreatment was investigated timely in accordance with facility policy. The findings include:Resident #1's diagnoses included Wernicke's encephalopathy (a neurological condition that causes confusion, eye movement abnormalities and gait abnormalities), a history of alcohol dependence, and atrial fibrillation (an irregular heart rate). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of nine (9) indicative of moderately impaired cognition and was independent with bed mobility, transfers and ambulation. The Resident Care Plan (RCP) dated 6/12/2025 identified that Resident #1 had behavior issues including a history of a resident-to-resident altercation with a previous roommate (on 5/31/2025 Resident #1 grabbed his/her roommate's shirt and verbally threatened the roommate). Interventions directed to explain the importance of seeking staff assistance with solving issues with other residents rather than engaging in assaultive behavior, observe for signs of irritability and difficulties with other residents, provide support to manage potentially stressful encounters with others, psychiatric consults per physician's orders, and social service support as needed. A nursing note dated 6/30/2025 at 3:15 PM written by RN #2, identified that NA #1 reported that over the weekend she heard Resident #1 make a statement that was concerning to her. Advanced Practice Registered Nurse (APRN) #1 was notified and ordered a psychiatric consult. Telehealth psychiatric consult was scheduled for 5:00 PM, and Resident #1 was placed in the lounge area with staff. Interview with NA #2 on 7/21/2025 at 1:05 PM identified on 6/28/2025 (Saturday) she was in the dining room when she heard Resident #1 stating to a female resident that he/she was going to be out of here soon because he/she was going to choke someone. NA #2 indicated Resident #1 made the comment in a threatening tone and she knew the resident had a history of assaulting another resident, so she reported the incident to RN #3/nursing supervisor immediately. NA #2 further indicated RN #3 dismissed her and didn't go to see the resident. NA #2 stated she notified RN #3 again on 6/29/2025 (Sunday) but that he again dismissed her and didn't go to talk with the resident, so she then reported it on 6/30/2025 to RN #2. Interview with RN #3 on 7/21/2025 at 1:26 PM identified that he did not recall NA #2 notified him on 6/28 and 6/29/2025 that Resident #1 had threatened to choke someone. An interview with RN #2/nursing supervisor on 7/21/2025 at 12:48 PM identified on 6/30/2025 (Monday), NA #2 reported she had heard Resident #1 say that he/she was going to strangle someone in the dining room on 6/28/2025. RN #2 indicated she then reported the allegation to administration immediately. Although attempted, an interview with DNS #2 (previous DNS) was not obtained during the survey. Interview with the Administrator on 7/21/2025 at 12:34 PM identified that although she was notified on 6/30/2025 that Resident #1 threatened to choke someone, she did not act on the allegation because the comment was not directed at any specific resident. The Administrator indicated the allegation was not investigated; she indicated she was unable to locate an incident report and believed it was not completed. Interview identified RN #3 should have acted on the reported threat when it was reported on 6/28 and 6/29/2025 and failed to identify why staff did not notify administration when NA #2 reported the incident. Further, interview identified when the allegation was reported on 6/30/2025, the facility should have completed an incident report with an investigation. Review of the facility undated Abuse Policy directed in part, any staff member witnessing or suspecting abuse must immediately report it to a supervisor who should then immediately notify the DNS and the Administrator. An A & I (accident & incident) report will be completed for each resident involved. The Administrator/DNS or designee will initiate an investigation. The investigation will include interviews with all witnesses, interviews with any individuals with relevant information, signed and dated statements from all parties involved. The outcome of the investigation and any corrective actions will be documented in the internal investigation report.