STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075089	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Middletown	600 Highland Ave Middletown, CT 06457

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for accidents, the facility failed to ensure an Elopement Risk evaluation was completed on admission to the facility per facility policy. The findings include:Resident #1?s diagnoses included dementia with anxiety, mild cognitive impairment, schizoaffective disorder, bipolar type (chronic mental health condition combining symptoms of delusions and hallucination with severe mood swings and episodes of mania), muscle weakness, type II diabetes mellitus and atrial fibrillation (a heart arrhythmia that prevents blood from pumping efficiently and increases the risk of blood clots and stroke).A Nursing admission assessment dated [DATE] failed to identify completion of the required Elopement evaluation. It was not identified whether Resident #1 was or was not at risk for elopement.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11) and was independent with bed mobility and ambulation without an assistive device.The Resident Care Plan (RCP) dated 2/24/26 identified Resident #1 required staff assistance with Activities of Daily Living (ADLs) and was a fall risk due to multiple risk factors. Interventions included encouraging the resident to ask and wait for staff assistance for transfers and transferring the resident per physician's orders. The RCP identified Resident #1 had cognitive impairment, a positive PASRR level of care due to psychiatric diagnoses, inappropriate behavior and could be resistive to treatment/care. Interventions included discussing implications of not complying with therapeutic regime and eliciting family input for best approaches to the resident.A nurse's note dated 5/8/26 at 10:32 PM by LPN #1 identified Resident #1 returned from a leave of absence (LOA) despite no evidence of a responsible party approval for an LOA on that date. A body audit was completed and no changes were observed, vital signs were stable, blood glucose was 172 and Resident #1 denied pain or discomfort. Resident #1 ate his/her dinner and snack, tolerated all medication with no adverse effects and was sleeping in bed with the call light within reach.The Police Report dated 5/8/26 identified at approximately 6:01 PM officers were dispatched to the facility for reports of a missing person. On arrival, nursing staff reported Resident #1 took off thirty (30) minutes prior and could not be located. Staff identified they last saw Resident #1 outside on the patio, and when they went to administer evening medications, they were unable to locate Resident #1 and were concerned due to his/her altered mental status. The Regional Administrator arrived on scene and reported she spoke with Resident #1's family (Person #2) who identified Resident #1 had been acting suspicious earlier in the evening and they were concerned Resident #1 left with Person #3 who he/she is not permitted to have contact with per the facility, but no protective order was in place. The surveillance cameras were reviewed and identified Resident #1 left the premises at 3:25 PM (over 2.5 hours prior to the police being notified) and spent over an hour pacing the front side walks and talking on his/her phone. At 7:15 PM, officers ?pinged' Resident #1's cell phone, the area was searched and a nearby hotel confirmed Person #3 had been staying at that hotel and offered the room number. Officers were let into the room and Resident #1 was found hiding in the bathroom. The Regional Administrator was notified and drove to the hotel to transport Resident #1 back to the facility.Review of the clinical record from 11/16/25 through 5/8/26 failed to identify (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an initial Elopement Risk evaluation was completed or that an Elopement Risk evaluation was completed subsequent to the incident.Interview with RN #2 on 6/10/26 at 2:01 PM identified she performed the Nursing admission assessment on 11/15/26 but was unable to explain why the assessment was not completed to indicate if Resident #1 was at risk for elopement. RN #2 identified the assessment should have been completed on admission.Interview with the DON on 6/10/26 at 2:39 PM identified the Elopement evaluation should have been completed on admission to the facility and quarterly, and again after the resident went missing on 5/8/26. She reported she was unaware the evaluations had not been completed. The post-incident evaluation was needed to prevent further elopement incidents and to implement appropriate individualized safeguards.Review of the Elopement Risk policy (undated) directed, in part, all residents are evaluated for risk of elopement on admission and readmission. Every resident admitted to the facility will be evaluated for elopement risk. A care plan will be developed and individualized interventions implemented if the resident is identified to be an elopement risk per the Elopement Risk evaluation.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews, the facility failed to provide adequate supervision and failed to implement required elopement prevention processes for one (1) of three (3) sampled residents (Resident #1) reviewed for accidents. Resident #1 had documented cognitive impairment, required staff assistance for ambulation outside the room, did not have approval for an independent Leave of Absence (LOA), and did not have a completed Elopement Risk evaluation as required by facility policy. The facility permitted Resident #1 to sit outside without supervision, failed to monitor Resident #1's whereabouts, and failed to follow missing resident procedures. As a result, Resident #1 eloped from the facility and was later located by law enforcement at a hotel approximately four (4) miles away. The findings include:Resident #1's diagnoses included dementia with anxiety, mild cognitive impairment, schizoaffective disorderˆbipolar type, muscle weakness, type II diabetes mellitus, and atrial fibrillation.A Preadmission Screening and Resident Review (PASRR) Level II dated 11/12/25 identified Resident #1 required 24ˆhour supervision for safety and had an assigned Conservator of Person (Person #6).A Nursing admission assessment dated [DATE] failed to identify completion of an Elopement Risk Evaluation.A physician order dated 11/19/25 directed Resident #1 was independent with ambulation inside the room and required oneˆperson assistance with a gait belt for ambulation in the hallways. The order did not authorize independent ambulation outdoors.A physician order dated 11/23/25 directed Resident #1 may go on LOA only with a responsible party.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11), required partial assistance for toilet transfers, and was independent with bed mobility and ambulation without an assistive device.The Resident Care Plan (RCP) dated 2/24/26 identified Resident #1 required staff assistance with Activities of Daily Living (ADLs) and was a fall risk due to multiple risk factors. Interventions included encouraging Resident #1 to ask and wait for staff assistance for transfers and to transfer per physician orders. The RCP identified cognitive impairment, a positive PASRR level of care due to psychiatric diagnoses, inappropriate behaviors, and resistance to care. Interventions included discussing implications of not complying with the therapeutic regimen and requesting family input regarding approaches to care.A Capacity to Meet Minimal Basic Needs Interview dated 2/28/26 identified Resident #1 could not meet basic needs in the community.A review of the clinical record from 11/16/25 through 5/8/26 failed to identify a completed Elopement Risk evaluation.A nurse's note by LPN #1 dated 5/8/26 at 10:32 PM identified Resident #1 returned from LOA despite the absence of documentation supporting responsibleˆparty approval for an LOA on that date.A review of nurse's notes from 5/1/26 through 5/8/26 failed to identify approval from Person #6 for an LOA on 5/8/26.The Police Report dated 5/8/26 identified at approximately 6:01 PM officers were dispatched to the facility for reports of a missing person. On arrival, nursing staff reported Resident #1 took off thirty (30) minutes prior and could not be located. Staff identified they last saw Resident #1 outside on the patio, and when they went to administer evening medications, they were unable to locate Resident #1 and were concerned due to his/her altered mental status. The Regional Administrator arrived on scene and reported she spoke with Resident #1's family (Person #2) who identified Resident #1 had been acting suspicious earlier in the evening and they were concerned Resident #1 left with Person #3 who he/she is not permitted to have contact with per the facility, but no protective order was in place. The surveillance cameras were reviewed and identified Resident #1 left the premises at 3:25 PM (over 2.5 hours prior to the police being notified) and spent over an hour pacing the front side walks and talking on his/her phone. At 7:15 PM, officers ?pinged' Resident #1's cell phone, the area was searched and a nearby hotel confirmed Person #3 had been staying at that hotel and offered the room number. Officers were let into the room and Resident #1 was found hiding (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the bathroom. The Regional Administrator was notified and drove to the hotel to transport Resident #1 back to the facility.A review of the clinical record from 5/8/26 through 6/10/26 failed to identify documentation of Resident #1 leaving the facility, missing resident procedures, a timeline of events consistent with the Police Report, or a completed Elopement Risk evaluation following the incident.An interview with NA #1 on 6/10/26 at 11:27 AM identified that on 5/8/26 she last observed Resident #1 around 3:00 PM sitting in the lobby with a family member. She reported Resident #1 routinely ambulated independently around the facility and sat outside unsupervised. At approximately 4:00 PM, she could not locate Resident #1. LPN #1 informed her that LPN #2 opened the door and allowed Resident #1 to go outside. NA #1 assumed LPN #1 and the Receptionist were supervising Resident #1. At 5:30 PM, LPN #1 informed her Resident #1 could not be found, a missing person code was called, and police were notified.An interview with Resident #1 on 6/10/26 at 11:58 AM identified that since admission to the facility, she/he requested an LOA with Person #3, and was informed that was not permitted. Resident #1 reported asking to sit in the front area on 5/8/26 and leaving without notifying staff. Resident #1 reported walking to a nearby store, being picked up by Person #3 and going to a hotel.An interview with LPN #1 on 6/10/26 at 12:20 PM identified she was receiving report around 3:00 PM on 5/8/26 when Resident #1 requested to go outside. LPN #2 entered the door code and permitted Resident #1 to ambulate to the patio. LPN #1 was unaware of the physician order requiring oneˆperson assistance outside the resident's room and did not check on Resident #1. She identified her note incorrectly documented that Resident #1 left on an LOA and reported RN #1 directed her to document that. She identified that if Resident #1 had left on an approved LOA, she would have documented before Resident #1 left the facility.An interview with the Rehab Director on 6/10/26 at 12:40 PM identified Resident #1 had not been evaluated for ambulation on uneven outdoor surfaces due to refusing prior assessments. Nursing should have submitted a screen if Resident #1 desired to ambulate outside independently. Resident #1 was not safe to be unsupervised or ambulate outside independently on 5/8/26.An interview with Person #5 (assistant to Person #6) on 6/10/26 at 1:26 PM identified Resident #1 was not approved for an independent LOA on 5/8/26 and that staff were not to permit contact between Resident #1 and Person #3 due to safety concerns.An interview with the Receptionist on 6/10/26 at 1:52 PM identified she was unaware Resident #1 went outside. She reported Resident #1 often paced outside and returned without issue, and if notified, she would have checked every few minutes. She reported she was not aware Resident #1 was outside until LPN #1 asked her at approximately 5:30 PM.An interview with RN #2 on 6/10/26 at 2:01 PM identified she completed the Nursing admission assessment on 11/15/25 and could not explain why the Elopement Risk evaluation was not completed. She identified LPN #2 should have reviewed orders prior to allowing Resident #1 outside and notified the Receptionist. Resident #1 did not sign out for an LOA. RN #2 initiated the missing person code and notified police.An interview with the Director of Nursing (DON) on 6/10/26 at 2:39 PM identified the Elopement Risk Evaluation should have been completed on admission and quarterly. She identified that staff should verify supervision needs before permitting a resident outside, that LPN #2 should have notified the Receptionist, and that documentation of the missing resident incident was not completed. She identified LPN #1 should not have documented inaccurate information.An interview with the Regional Administrator on 6/10/26 at 3:08 PM identified she reviewed surveillance footage that showed Resident #1 outside at 3:10 PM and leaving the camera view at 3:25 PM. She identified Resident #1 did not sign out on an LOA and was not approved by Person #6 to leave independently. She retrieved Resident #1 from the hotel after police located Resident #1.The facility reported the incident to the State Agency on 6/10/26.Although attempted, interviews with Person #2, Person #3, RN #1, and LPN #2 were unsuccessful.Although requested, documentation pertaining to responsibleˆparty approval for an LOA on 5/8/26 was not provided.The Missing Resident, Unauthorized Leave, and Elopement Response policy directed that residents at risk for harm, exploitation, injury, environmental exposure, or inability to meet basic needs were to be treated as highˆrisk missing residents and immediate search and notification procedures should be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated. The policy identified conditions requiring police notification, documentation requirements, and the need to base the response on assessed risk factors, cognitive status, known habits, and environmental conditions.The Leave of Absence (LOA) policy directed that all LOAs required provider authorization and that an LOA Risk Evaluation process should be used to identify support needs and safety concerns.The Elopement Risk policy directed that all residents be evaluated for elopement risk on admission and readmission and that a care plan be developed if the resident was identified as at risk.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews for one (1) of three (3) sampled residents (Resident #1), the facility failed to maintain a clinical record that was complete, accurate, and timely. Specifically, the facility failed to document that Resident #1 was missing from the facility on 5/8/26 and failed to ensure nursing documentation accurately reflected the circumstances of the resident's departure. These failures resulted in a clinical record lacking essential information needed to ensure continuity of care, accurate assessment, and a reliable account of significant events. The findings include:Resident #1's diagnoses included dementia with anxiety, mild cognitive impairment, schizoaffective disorderˆbipolar type, muscle weakness, type II diabetes mellitus, and atrial fibrillation.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 11) and was independent with bed mobility and ambulation without an assistive device.The Resident Care Plan (RCP) dated 2/24/26 identified Resident #1 required staff assistance with Activities of Daily Living (ADLs) and was a fall risk due to multiple contributing factors. Interventions included encouraging Resident #1 to ask and wait for staff assistance for transfers and transferring per physician orders. The RCP identified cognitive impairment, inappropriate behaviors, and resistance to care. Interventions included discussing implications of not complying with the therapeutic regimen and obtaining family input for approaches to care.A nurse's note by LPN #1 dated 5/8/26 at 10:32 PM identified Resident #1 returned from a Leave of Absence (LOA) despite no evidence of responsibleˆparty approval for an LOA that day.The Police Report dated 5/8/26 identified that at approximately 6:01 PM officers were dispatched to the facility for a missing resident. Staff reported Resident #1 left approximately thirty (30) minutes prior and could not be located. Staff identified Resident #1 was last seen on the patio and was not present when evening medications were attempted. Person #2 expressed concern Resident #1 may have gone with Person #3, with whom contact was not permitted. Surveillance footage identified Resident #1 left the premises at 3:25 PM. Police pinged the resident's cell phone and located Resident #1 at a hotel. Resident #1 was found in a bathroom and was retrieved by the Regional Administrator and returned to the facility.A review of the clinical record from 5/8/26 through 6/10/26 failed to identify documentation that Resident #1 was missing from the facility, that missing resident procedures were initiated, that police were notified, or that Resident #1 was returned by the Regional Administrator following police involvement. The clinical record did not include a timeline of the events described in the Police Report or documentation of required notifications.An interview with LPN #1 on 6/10/26 at 12:20 PM identified that on 5/8/26 she was receiving report around 3:00 PM when Resident #1 requested to go outside. LPN #2 opened the door and permitted Resident #1 to ambulate to the patio. LPN #1 did not check on Resident #1 and assumed the Receptionist was monitoring. At approximately 5:30 PM, LPN #1 searched outside, could not locate Resident #1, and notified RN #2. A missing person code was initiated and police were contacted. Resident #1 returned after 8:00 PM and reported leaving to see Person #3. LPN #1 identified her nurse's note incorrectly documented Resident #1 left on an LOA and reported RN #1 instructed her to document the event that way. She identified she would have documented prior to departure if an LOA had been approved.An interview with the Director of Nursing (DON) on 6/10/26 at 2:39 PM identified the missing resident incident should have been documented. The DON identified the nurse's note by LPN #1 contained inaccurate information and that there was no responsibleˆparty approval for an LOA on 5/8/26.An interview with the Regional Administrator on 6/10/26 at 3:08 PM identified Resident #1 had not signed out, had not been approved to leave independently, and police were contacted because Resident #1 could not be located. She retrieved Resident #1 from a hotel after police located the resident.The Missing Resident, Unauthorized Leave, and Elopement Response (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy (undated) directed that residents at risk for harm, exploitation, injury, environmental exposure, or inability to meet basic needs should be treated as highˆrisk missing residents and immediate search efforts and notifications should be initiated. The policy required documentation including the time the resident was discovered missing, circumstances surrounding the event, resident risk assessment, search efforts, notifications, assessment upon return, physician/provider orders, interventions, incident reporting, care plan updates, and followˆup actions.