

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab Guilford		STREET ADDRESS, CITY, STATE, ZIP CODE 10 Boston Post Rd 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 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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #3) reviewed for abuse, the facility failed to ensure a resident was protected from mistreatment when Resident #1, with known intrusive and sexual behaviors was witnessed to touch Resident #3 inappropriately. The findings include: 1. Resident #1's diagnoses included vascular dementia, adjustment disorder, and anxiety. 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 moderately impaired cognition and ambulated independently. The Resident Care Plan dated 8/11/2025 identified Resident #1 had a history of verbally abusive and sexually inappropriate behaviors (2/12, 6/21 and 12/8/2024). Interventions directed to monitor behaviors, attempt to redirect, remove from public areas when behavior is disruptive/unacceptable and psychiatric follow-up as needed. 2. Resident #3's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a BIMS score of nine out of fifteen (9/15), indicative of moderately impaired cognition and ambulated independently. The Resident Care Plan dated 8/11/2025 identified Resident #3 had dementia. Interventions directed to provide reminders and consistent daily routines. A facility incident report and investigation dated 8/12/2025 identified Resident #1 was observed with his/her hand on Resident #3's chest area. The incident report was classified as a Class E. The facility plan of correction directed medication changes for and one-to-one (1:1) monitoring until psychiatric clearance. Although attempted, an interview with SPN #1 (LPN Student) was unable to be obtained during the survey. A written statement by SPN #1 dated 8/12/2025, without a specified timeframe, identified SPN #1 was coming from a nursing unit, when she saw Resident #1 with his/her hand under Resident #3's shirt, touching his/her upper chest area. SPN #1 directed Resident #1 to stop, moved Resident #3 in his/her wheelchair away from Resident #1 and notified the charge nurse. APRN #2 progress note dated 8/12/2025 at 1:34 PM identified Resident #1 was seen via telehealth platform for risk assessment and evaluation of impulsive/behavior after an alleged inappropriate sexual behavior on unit. Resident #1 was not at baseline and was making more bizarre impulsive comments. Presented with mild anxiety/hypomania during exam; answered all questions but had difficulty focusing and remaining on task, difficulty grasping seriousness of conversation, and joked intermittently. Thought content was disorganized and denied any memory of alleged incident though is grossly oriented to everything except situation. No signs/symptoms of psychosis, denied thoughts of wanting to harm self/others or make any physical contact with others. New orders for antipsychotics for behaviors. No imminent risk to self/others and directed to discontinue the 1:1 monitoring. Interview with APRN #1 on 10/16/2025 at 12:15 PM identified Resident #1 required behaviors monitored by staff, and re-directed as needed for inappropriate behaviors. Interview with the DON on 10/16/2025 at 1:25 PM identified for the incident observed by SPN #1 on 8/12/2025 was inappropriate behavior. The DON stated the nursing staff should have been vigilant monitoring Resident #1's location and behaviors to prevent the incident. Interview failed to identify Resident #3 had the capacity to consent, and why the staff did not monitor Resident #1's location to prevent the incident. Review of the undated facility Abuse Policy and Procedure directed in part, sexual abuse was any form of sexual harassment, coercion, or assault, including unwanted touching between residents.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for two of three residents (Resident #1 and #3) reviewed for abuse, the facility failed to report an allegation of abuse to the State Agency in a timely manner. The findings include: 1. Resident #1's diagnoses included vascular dementia, adjustment disorder, and anxiety. 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 moderately impaired cognition and ambulated independently. The Resident Care Plan dated 8/11/2025 identified Resident #1 had a history of verbally abusive and sexually inappropriate behaviors (2/12, 6/21 and 12/8/2024). Interventions directed to monitor behaviors, attempt to redirect, remove from public areas when behavior is disruptive/unacceptable and psychiatric follow-up as needed. 2. Resident #3's diagnoses included dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a BIMS score of nine out of fifteen (9/15), indicative of moderately impaired cognition and ambulated independently. The Resident Care Plan dated 8/11/2025 identified Resident #3 had dementia. Interventions directed to provide reminders and consistent daily routines. A facility incident report and investigation dated 8/12/2025 identified Resident #1 was observed with his/her hand on Resident #3's chest area. The incident report was classified as a Class E. The facility plan of correction directed medication changes for and one-to-one (1:1) monitoring until psychiatric clearance. Although attempted, an interview with SPN #1 (LPN Student) was unable to be obtained during the survey. A written statement by SPN #1 dated 8/12/2025, without a specified timeframe, identified SPN #1 was coming from a nursing unit, when she saw Resident #1 with his/her hand under Resident #3's shirt, touching his/her upper chest area. SPN #1 directed Resident #1 to stop, moved Resident #3 in his/her wheelchair away from Resident #1 and notified the charge nurse. Review of CT's Department of Health's FLIS Events Report Tracking System identified the facility failed to submit a reportable event to the State Agency for observed incident that occurred on 8/12/2025 between Resident #1 and Resident #3. Interview with the DON on 10/16/2025 at 1:25 PM identified the facility did not report the incident to the State Agency, as they determined to not meet the level of abuse. DON stated that since the event was witnessed, there was no intention of harm, no injuries, no signs of distress from Resident #3, and the families did not have any concerns. DON identified the facility classified the event as an Class E since the facility did not believe it met the qualifications of an alleged abuse. Review of the undated facility Abuse Policy and Procedure directed in part, sexual abuse was any form of sexual harassment, coercion, or assault, including unwanted touching between residents. The policy further directed, the DON or designee will notify the DPH (Department of Public Health), and local authorities as needed, and submit an online report to FLIS (Facility Licensing and Investigations Section) within two (2) hours of notification.</p>		