STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for elopement, the facility failed to ensure supervision to prevent a resident with dementia from leaving the building without staff knowledge. The failure resulted in staff being unaware Resident 1 was missing from the facility until notified by the local police. The findings include: Resident #1 was admitted to the facility with diagnoses that included dementia, cardiomyopathy (enlarged heart), nicotine dependence, and chronic kidney disease. Record review identified Resident #1 had a court appointed Conservator of Person. The Resident Care Plan (RCP) dated 10/15/2025 identified Resident #1 had dementia, required assistance with ADLs, and had poor judgement and decision making. Interventions directed to assist with care as needed. Record review identified Resident #1 had no physician orders for any Leave of Absence from the facility. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a diagnosis of dementia, had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment and was independent for transfers and mobility. A police call summary report dated 12/27/2025 identified the police received a call at 6:31 PM regarding a male observed lying in the snow and the caller did not think individual was ok. Police welfare check found Resident #1 had fallen face first in the snow, could not talk and was missing a shoe. An ambulance was called and Resident #1 was transferred to the hospital. The ambulance run report dated 12/27/2025 identified Emergency Medical Services (EMS) responded at 6:41 PM to an address (0.5 miles from the facility) to a cold snowbank in a residential area at the request of local police. On arrival, they found Resident #1 with the police, confused, covered in snow and wet clothing, and missing one (1) shoe. The police reported finding Resident #1 face down in snowbank, disoriented and agitated on their arrival. Skin was pink/cold/wet from the snow. Resident #1 was assisted into ambulance where top layer of wet clothing was removed, heat in passenger compartment turned all the way up and Resident #1 was wrapped in dry blankets. Vital signs were stable. Resident #1 reported he/she left the facility to buy cigarettes, could not recall when he/she left the facility, was cold, could not recall when he/she left the facility, or how long he/she had been walking. Resident #1 was found approximately half a mile from facility. A hospital emergency department note dated 12/27/2025 identified Resident #1 arrived by ambulance at 7:20 PM after he/she was found in a snowbank by police with altered mental status and was wearing only one (1) shoe. Resident #1 reported he/she had snuck out of facility to get cigarettes and had slipped in the snow and fell twice, denying head strike. Resident #1 was able to wiggle his/her toes, with bilateral feet very cold to touch. Resident #1 was diagnosed with fall and frostnip. Hospital Discharge summary dated [DATE] identified Resident #1 was placed on observation for case management after being found outside in the cold with one (1) shoe. Conservator was contacted and agreed with plan for discharge. A facility Reportable Event form dated 12/27/2025 identified Resident #1 was independent for transfers and ambulation without any assistive device. The Report identified Resident #1 intentionally exited the facility for a brief time frame to obtain cigarettes, was located approximately half a mile away by police and sustained no injury. Resident #1 was transported to the hospital for evaluation. A review of the local weather identified the outside temperature was 13 degrees Fahrenheit (F) from 5:54 PM to 6:54 PM with light snow. Sunset was at 4:28 PM. Review of area map identified that main road to be a 2-lane road with a sidewalk and posted speed limit of 45 miles per hour. Review of written statement dated 12/27/2025 by NA #2 identified she last saw Resident #1 in the dining room at 5:40 PM. Nursing note dated 12/27/2025 at 10:18 PM identified the facility was notified by the local police that Resident #1 was found in town at about 6 PM and transferred to the hospital. Resident #1 left the building without permission or signing out, and was last seen during and after dinner. Nursing note dated 12/29/2025 at 1:34 PM identified Resident #1 returned to the facility at 12:45 PM. Interview with RN #1 (nursing supervisor on 12/27/2025) on 12/31/2025 at 1:30 PM identified that at approximately 8:15 PM she received a phone call from the local police department that Resident #1 had been found outside the facility about a half (1/2) mile away from the facility and was transported to the hospital for evaluation. RN #1 stated she immediately went to the lobby and checked the front door to make sure it was locked as the door automatically locked at 8:00 PM. The door was secure, and she notified the DON. The DON directed RN #1 to do an immediate bed check to account for the remaining residents. RN #1 stated Resident #1 was not an elopement risk but ambulated independently and walked around the facility. RN #1 stated she had last seen Resident #1 at the 4:00 PM