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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075231	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Colchester	36 Broadway Street Colchester, CT 06415

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for four of six residents (Resident #1, Resident #2, Resident #3, and Resident #4) reviewed for abuse, the facility failed to ensure the residents were free from abuse. The findings include: 1. A. Resident #1's diagnoses included dementia with behavioral disturbances, panic disorder, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition and was supervision for mobility without an assist device. The Resident Care Plan (RCP) dated 8/8/2024 identified Resident #1 had the potential for altered mood related to diagnosis of dementia, panic disorder, anxiety disorder, and depression. Interventions directed to provide redirection and ensure resident and other's safety if resident appeared upset or angry. B. Resident #2's diagnoses included traumatic brain injury, dementia with behavioral disturbance, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition and was substantial assistance for mobility with wheelchair. The RCP dated 8/7/2024 identified Resident #2 had a memory deficit with alteration in decision making and thought process. Interventions directed to place resident to an area that is away from noisy areas to promote a higher level of safety. Record review identified Residents #1 and #2 were roommates. A reportable event form dated 8/11/2024 at 10:20 PM identified on 8/12/2024 a staff member reported witnessing Resident #1 hit Resident #2 on the right side of his/her ribs. Resident #1 was separated from Resident #2, provided an alternative room for the night and placed on close observation until seen by psych services. Review of NA #4 written statement dated 8/11/2024 identified Resident #1 came up to NA #4 and pushed the laundry cart into NA #4 and another NA. Resident #1 then went into his/her room and then NA #4 heard Resident #2 yelling. When NA #4 entered the room he/she observed Resident #1 slapping Resident #2 in the stomach/rib area. Review of the incident summary dated 8/17/2024 identified the allegation of abuse was unsubstantiated. (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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NAME OF PROVIDER OR SUPPLIER Apple Rehab Colchester		STREET ADDRESS, CITY, STATE, ZIP CODE 36 Broadway Street Colchester, CT 06415	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 9/11/2024 at 1:15 PM identified she did not substantiate abuse because she thought the incident was behavioral and it was not intentional. 2. Resident #3's diagnoses included Alzheimer's disease, dementia, and anxiety disorder. The admission assessment dated [DATE] identified Resident #3 had severely impaired cognition and was independent for mobility without an assistive device. The Resident Care Plan (RCP) dated 8/23/2024 identified Resident #3 had impaired memory, and decision-making skills related to dementia. Interventions directed to allow time for resident to respond when communicating. A reportable event form and investigation dated 8/24/2024 at 1:30 PM identified Resident #3 was hit in the chest by Resident #1. Residents were immediately separated and social services/psychiatry followed up with both residents. A nursing note dated 8/24/2024 at 2:45 PM by LPN #2 identified Resident #1 had been physically aggressive with staff and other residents. Resident #1 started throwing items and pushed over a bed table onto LPN #1, and Resident #1 was seen punching Resident #3. Resident #1 was agitated and difficult to redirect, and the Supervisor was notified. Interview with the DON on 9/11/2024 at 1:15 PM identified she did not substantiate abuse because she thought the incident was behavioral and it was not intentional. 3. A reportable event form and investigation dated 8/26/2024 at 2:36 PM identified Resident #1 pushed Resident #3 as he/she was ambulating on the unit. The DON assessed the residents and observed Resident #1 ambulating toward the door. The DON immediately placed Resident #1 on one-to-one (1:1) observation and the DON accompanied Resident #1 back to his/her room. As the DON was holding Resident #1's hand to accompany him/her back to his/her room they walked past Resident #2 who was sitting in his/her wheelchair. As they passed Resident #2, Resident #1 walked over to Resident #2 and hit him/her in the left eye. The report indicated the DON attempted to stop Resident #1 but was not quick enough. The DON then directly assisted Resident #1 to his/her room. Resident #1 and #3 were assessed by the nurse and identified no injuries. APRN #2 (who was present in the facility) was notified and orders were obtained to transfer Resident #1 to the hospital for evaluation. Facility incident summary dated 9/4/2024 identified there were no prior incidents between Resident #1 and #2. Further, the summary identified Resident #1 was unable to state why he/she was aggressive toward Resident #2. Interview with the DON on 9/18/2024 at 10:25 AM identified on 8/26/24, she was called to the unit to assist with Resident #1's behaviors. The DON stated staff reported Resident #1 had pushed Resident #3, and upon her arrival, DON attempted to re-direct and calm Resident #1 by bringing him/her to his/her room. The DON stated she held Resident #1's hand as she walked Resident #1 to his/her room, and when she stopped at the nursing station, Resident #1 let go, walked over to Resident #2 and hit Resident #2 in his/her left eye. The DON immediately separated the residents and Resident #1 was transferred to the hospital for evaluation. The DON stated Resident #1 was readmitted to the facility on [DATE]. Interview with the DON on 9/11/2024 at 1:15 PM identified she did not substantiate abuse because she thought the incident was behavioral and it was not intentional. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Resident #4's diagnoses included dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was alert and oriented and was independent for mobility without an assist device. The Resident Care Plan (RCP) dated 7/31/2024 identified Resident #4 had impaired memory and decision-making skills related to dementia. Interventions directed to allow time for resident to respond when communicating. A reportable event form and investigation dated 9/2/2024 at 4:15 PM identified a NA witnessed Resident #1 wander into Resident #4's room and hit Resident #4's arm and Resident #4 then hit Resident #1 back. The residents were immediately separated. Both residents were assessed for injuries with no injuries identified. Both residents were placed on every 15-minute check until psychiatry evaluations were completed. Review of NA #5 written statement dated 9/2/2024 identified NA #5 was fixing Resident #4's blanket when he/she observed Resident #1 and Resident #4 slap each other. Interview with NA #5 was not obtained during survey. Interview with the DON on 9/11/2024 at 1:15 PM identified she did not substantiate abuse because she thought the incident was behavioral and it was not intentional. The DON indicated the residents were evaluated after each incident above and deemed safe. After the incident on 9/2/2024, Resident #1 was transferred and admitted to the hospital. Review of facility Abuse/Resident Policy dated 7/23/2023 identified abuse and mistreatment of any kind toward a resident is strictly prohibited. Abuse shall be defined as: abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for four of eight residents (Resident #1, #2, #3, and #4) reviewed for abuse, the facility failed notify the State Agency of an allegation of abuse in a timely manner. The findings include: 1. A. Resident #1's diagnoses included dementia with behavioral disturbances, panic disorder, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition and was supervision for mobility without an assist device. The Resident Care Plan (RCP) dated 8/8/2024 identified Resident #1 had the potential for altered mood related to diagnosis of dementia, panic disorder, anxiety disorder, and depression. Interventions directed to provide redirection and ensure resident and other's safety if resident appeared upset or angry. B. Resident #2's diagnoses included traumatic brain injury, dementia with behavioral disturbance, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition and was substantial assistance for mobility with wheelchair. The RCP dated 8/7/2024 identified Resident #2 had a memory deficit with alteration in decision making and thought process. Interventions directed to place resident to an area that is away from noisy areas to promote a higher level of safety. Record review identified Residents #1 and #2 were roommates. A reportable event form dated 8/11/2024 at 10:20 PM identified on 8/12/2024 a staff member reported witnessing Resident #1 hit Resident #2 on the right side of his/her ribs. Resident #1 was separated from Resident #2, provided an alternative room for the night and placed on close observation until seen by psych services. Review of NA #4 written statement dated 8/11/2024 identified Resident #1 came up to NA #4 and pushed the laundry cart into NA #4 and another NA. Resident #1 then went into his/her room and then NA #4 heard Resident #2 yelling. When NA #4 entered the room he/she observed Resident #1 slapping Resident #2 in the stomach/rib area. Review of the Department of Public Health's FLIS Reportable Event Tracking System identified the incident occurred on 8/11/2024 at 10:20 PM, and the State Agency was notified on 8/12/2024 at 10:02 AM (11 hours and 42 minutes) . 2. Resident #3's diagnoses included Alzheimer's disease, dementia, and anxiety disorder. The admission assessment dated [DATE] identified Resident #3 had severely impaired cognition and was independent for mobility without an assistive device. The Resident Care Plan (RCP) dated 8/23/2024 identified Resident #3 had impaired memory, and decision-making skills related to dementia. Interventions directed to allow time for resident to respond when communicating. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A reportable event form and investigation dated 8/24/2024 at 1:30 PM identified Resident #3 was hit in the chest by Resident #1. Residents were immediately separated and social services/psychiatry followed up with both residents. A nursing note dated 8/24/2024 at 2:45 PM by LPN #2 identified Resident #1 had been physically aggressive with staff and other residents. Resident #1 started throwing items and pushed over a bed table onto LPN #1, and Resident #1 was seen punching Resident #3. Resident #1 was agitated and difficult to redirect, and the Supervisor was notified. Review of the Department of Public Health's FLIS Reportable Event Tracking System identified the incident occurred on 8/24/2024 at 1:00 PM and the State Agency was notified on 8/26/2024 at 11:44 AM (76 hours and 44 minutes). 3. Resident #4's diagnoses included dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was alert and oriented and was independent for mobility without an assist device. The Resident Care Plan (RCP) dated 7/31/2024 identified Resident #4 had impaired memory and decision-making skills related to dementia. Interventions directed to allow time for resident to respond when communicating. A reportable event form and investigation dated 9/2/2024 at 4:15 PM identified a NA witnessed Resident #1 wander into Resident #4's room and hit Resident #4's arm and Resident #4 then hit Resident #1 back. The residents were immediately separated. Both residents were assessed for injuries with no injuries identified. Both residents were placed on every 15-minute check until psychiatry evaluations were completed. Review of NA #5 written statement dated 9/2/2024 identified NA #5 was fixing Resident #4's blanket when he/she observed Resident #1 and Resident #4 slap each other. Review of the Department of Public Health's FLIS Reportable Event Tracking System identified the incident occurred on 9/2/2024 at 4:15 PM, and the State Agency was notified on 9/3/2024 at 10:54 AM (18 hours and 39 minutes). Interview with the DON on 9/11/2024 at 1:15 PM identified all allegations of abuse are to be reported to the State Agency within two (2) hours. The DON indicated she was new to the facility. The DON indicated she spoke with staff about the incidents, and she felt the incidents were behavioral and not abuse. Review of facility Abuse/Resident Policy dated 7/23/23 directed in part, the Administrator/DON or designee will immediately conduct an investigation upon submission of a report of FLIS (Facility Licensing and Investigation Section) within two (2) hours of notification of alleged allegation of abuse.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for two residents (Resident #1 and #5) reviewed for behavioral health, the facility failed to accurately reflect the behaviors that were exhibited and treated. The findings include: 1. A. Resident #1's diagnoses included dementia with behavioral disturbances, panic disorder, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition and was supervision for mobility without an assist device. The Resident Care Plan (RCP) dated 8/8/2024 identified Resident #1 had the potential for altered mood related to diagnosis of dementia, panic disorder, anxiety disorder, and depression. Interventions directed to provide redirection and ensure resident and other's safety if resident appeared upset or angry. Physician orders dated 7/23/2024 directed to monitor for psychotropic behaviors. Monitor for the following: Itching/picking at skin, restlessness (agitation), hitting, increasing complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Physician orders dated 7/24/24 directed to administer Trazodone (antidepressant and sedative) 50 milligrams (mg) as needed (PRN) for anxiety. Review of the MAR (medication administration record) for the month of August 2024 identified Resident #1 received Trazodone 50 mg PRN on 8/4, 8/5, 8/10, 8/12, 8/13, 8/18, 8/21, 8/23, and 8/30/2024 for behaviors. Although review of the Medication Administration Record (MAR) identified there were no behaviors documented on 8/10, 8/12, 8/18 and 8/21/2024, Resident #1 received the PRN Trazodone. Review of the nursing notes failed to identify nursing staff noted the behaviors required per the physician orders (anxiety) for administration of the Trazodone on 8/10, 8/12, 8/18, and 8/21/24. 2. Resident #5's diagnoses included metabolic encephalopathy, dementia with behavioral disturbance, anxiety disorder and depression. Nursing admission assessment dated [DATE] identified Resident #5 had severe cognitive impairment and required assistance for mobility in a wheelchair. Physician orders dated 7/9/2024 directed to monitor for psychotropic behaviors. Monitor for the following: Itching/picking at skin, restlessness (agitation), hitting, increasing complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. The Resident Care Plan (RCP) dated 7/17/24 identified Resident #5 was at risk for potential adverse effects of psychotropic drug use related to diagnosis of anxiety disorder and depression. Interventions directed to monitor mood/behavior, and interactions with other residents for appropriateness. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 7/30/2024 directed to administer Trazodone (antidepressant and sedative) 25 mg as needed for anxiety. Although review of the MAR for August 2024 identified Resident #5 received PRN Trazodone 25 mg on 8/4, 8/5, 8/8, and 8/10/2024 for behaviors, no behaviors were documented on 8/4, 8/5, 8/8, and 8/10/2024. Review of the nursing notes failed to identify nursing staff noted the behaviors required (anxiety) per the physician orders for the administration of Trazodone on 8/4, 8/5, 8/8, and 8/10/2024. Interview with the DON on 09/11/24 at 1:15 PM identified the nursing staff documentation should accurately reflect a resident's behaviors, including documentation to support the need for a PRN medication to be administered to treat behaviors. Interview failed to identify why the behaviors were not monitored. Review of facility Behavior Monitoring/Antipsychotic Medication Policy dated 6/2019 directed in part, residents receiving anti-psychotic medications will have specific target behaviors identified and monitored every shift. Any time a resident is started on an antipsychotic medication, a behavior flow sheet will be initiated, target behavior(s) will be recorded were indicated on the flow sheet, each shift will record, the number of episodes for each behavior, interventions, outcomes and side effects and nursing documentation will be done by exception.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for all residents (fifty-seven), reviewed for administration, the facility failed to ensure medications were documented during an electronic charting system outage. The findings include: Review of the MARs for all fifty-seven (57) residents, failed to identify medications were documented during the 11:00 PM to 7:00 AM shift on 9/7in to 9/8/2024. Interview with the DON on 9/11/2024 at 1:15 PM identified on the 11:00 PM to 7:00 AM shift on 9/7 to 9/8/2024, the electronic charting system went down, and the nurses were not able to document the medications. The DON stated the facility was unable to provide any form of verification that the medications were administered. Subsequent to surveyor inquiry, the DON indicated the facility will ensure paper documentation will be initiated upon the next reported outage to ensure documentation is complete. Review of the facility undated PCC (point click care) eMAR Downtime Policy directed in part, for an unplanned downtime, directs staff to immediately switch to paper MARs or backup forms. During downtime, use paper MARs to document all medications (include resident name, medication details, time, and staff initials/signatures). After downtime, enter all paper MAR data into PCC once the system is restored or ensure paper tracking is stored in resident's hard chart. Ensure all information is accurate and complete.