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	05/06/2025

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 0689 Level of Harm - 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 reviews, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for falls, the facility failed to ensure Resident #1's bed was in the lowest position prior to leaving the room to minimize or prevent an injury. The findings include: Resident #1's diagnoses included cerebellar ataxia (loss of muscle coordination) and a history of falls. The Resident Care Plan dated 3/25/25 identified Resident #1 had a history of falls. Interventions included a low bed with floor mats, body pillows to provide bed boundaries, and remove the bed controller while the resident in bed to prevent the resident from positioning the bed in a high position. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Basic Interview for Mental Status (BIMS) score of 11 out of 15 indicating some memory recall deficits and was dependent on staff for activities of daily living. The nurse aide care card identified revised on 3/30/25 directed for the bed to be placed in the lowest position. The nurse's note dated 4/8/25 at 9:36 AM identified the 7AM-3PM Nursing Supervisor was called to Resident #1's room with a report that Resident #1 had a fall, Resident #1 was noted to be on the floor on the left side of the bed, lying on his/her left side with a bump on the head. The note indicated Resident #1 was assessed, neuro checks, and vital signs were stable, the physician was called, directed to transfer Resident #1 to the Emergency Department, and Resident #1 was transferred at 9:35 AM. The nurse's note dated 4/8/25 at 11:23 PM identified Resident #1 returned to the facility around 7:00 PM with a neck brace. Resident #1 sustained fractures of the C6 and C7 spine and a hematoma to the forehead. The hospital Discharge summary dated [DATE] identified Resident #1 sustained a small neck fracture not requiring surgery and the recommendation was to keep the collar on and follow-up with the neurosurgeon. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	The summary report dated 4/12/25 identified at approximately 9:10 AM Resident #1 was observed on the floor next to the bed. The investigation identified Resident #1 was upright in bed being fed by staff. The nurse aide noted Resident #1 was not swallowing the food, she went to get the nurse and upon return to the room, Resident #1 was noted to be on the floor. Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 5/7/25 at 10:50 AM identified she was called to Resident #1's room after Resident #1 fell out of the bed onto the floor. RN #1 stated she assessed the resident's vital signs and neuro checks to be within normal limits, Resident #1 sustained a bump on the head with slight bleeding, and Resident #1 was transferred to the hospital. RN #1 identified the bed was at waist height, and it should have been in the lowest position when staff are not in the room. Interview with the 7AM-3PM charge nurse, RN #2, on 5/7/25 at 11:15 AM identified she was called into Resident #1's room to assist RN #1 after Resident #1's fall out of bed onto the floor. RN #2 indicated Resident #1 had been declining in health, becoming more restless and agitated, had recent falls, and the bed was always to be in the lowest position. RN #2 identified that when Resident #1 fell, the bed was not in the lowest position. Interview with the 7AM-3PM nurse aide, Nurse Aid (NA) #2, on 5/7/25 at 11:25 AM identified that she had raised Resident #1's bed to waist height to feed Resident #1 breakfast. NA #2 explained she did not return the bed to its lowest position before she left the room, even though she knew the care card directed to always have the bed in the lowest position, because the pillows were all around Resident #1. Review of the Fall: Minimizing Risk of Injury Policy identified that Residents who experience a fall will be evaluated following the occurrence using the interdisciplinary assessment tool to identify the potential causes of the fall, an individualized care plan, and updated interventions as needed to prevent falls and minimize injuries.