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	12/03/2025

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 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. (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 0658 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 reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for falls, the facility failed to ensure the resident was fully assessed by the nurse following a fall with pain and possible injury prior to staff transferring the resident back to bed and failed to ensure a fall risk assessment was completed for the resident per facility policy. The findings include: Resident #1's diagnoses included muscle weakness, cognitive communication deficit, anxiety, depression and schizoaffective disorder (a mental health condition marked primarily by symptoms of schizophrenia such as hallucinations and delusions). The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating Resident #1 rarely or never made decisions regarding task of daily living and was dependent on staff for toileting, bed mobility and transfers. The Resident Care Plan dated 10/17/25 identified that Resident #1 was at risk for falls due to multiple risk factors including poor safety awareness and generalized weakness. Interventions directed a low bed, encouraging the resident to ask and wait for staff assistance for transfers and/or toileting, utilizing the call bell for assistance, therapy evaluation and treatment as needed and pharmacy and psychiatric medication reviews. The nurse's note dated 10/18/25 at 4:26 AM identified at 3:40 AM Resident #1 was observed lying in the middle of his/her room, reporting he/she transferred him/herself and ambulated unassisted, leading to the unwitnessed fall. The note identified Resident #1 was complaining of left hip pain and upon assessment, left hip erythema (redness of the skin) was present, no internal or external rotation was observed but limited range of motion was noted to the left lower extremity with complaints of pain ten, ten (10) out of ten (10), with movement. The note indicated Resident #1 was assisted back to bed, the Advanced Practice Registered Nurse (APRN) was notified and orders were obtained for a STAT (immediate) x-ray to the left hip and pelvis, Resident #1 was to remain on bedrest until the x-ray results were received and to apply ice to the left hip for ten (10) minutes every shift for three (3) days. Review of the imaging report dated 10/18/25 identified Resident #1 had sustained an acute (new) left femoral (thigh bone) intertrochanteric fracture (a femur fracture just below the hip joint). The nurse's notes dated 10/18/25 identified Resident #1 was transferred to the hospital via ambulance at 12:45 PM and admitted for the left intertrochanteric fracture. The hospital documentation identified Resident #1 underwent a left femur intramedullary nailing (a surgical procedure where a metal rod is inserted into the center of the femur and is secured with screws at both ends) on 10/19/25. Review of the clinical record failed to identify fall risk assessments had been completed prior to the 10/18/25 fall despite having ten (10) falls from 3/14/25 through 10/15/25 or after the 10/18/25 fall. Interview with 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1, on 11/10/25 at 12:37 PM identified that on 10/18/25 at 3:40 AM she heard a noise from Resident #1's room and when she responded she observed Resident #1 sitting on the floor several feet from the bed and when Resident #1 saw her he/she began yelling dolor (pain in Spanish). LPN #1 explained the nurse aide, Nurse Aide (NA) #1, also responded and she then immediately notified the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1. LPN #1 identified although Resident #1 was anxious and yelling out in pain with any movement, RN #1 directed her and NA #1 to assist in standing Resident #1 prior to Resident #1 being assessed, and Resident #1 repeatedly yelled dolor during the three (3) person stand-pivot transfer back to bed. Interview with RN #1 on 11/10/25 at 1:11 PM identified when he responded to Resident #1's room on 10/18/25 following the fall, Resident #1 was yelling out and was in visible pain and he knew something was wrong. RN #1 explained Resident #1 was very anxious and wanted to get up, but instead of attempting to make Resident #1 comfortable on the floor and assessing him/her with help from other staff to rule out any injuries prior to transferring Resident #1, he directed LPN #1 and NA #1 in assisting him in standing Resident #1 to get Resident #1 back to bed. RN #1 identified Resident #1 was very guarded, tense and yelled out in pain numerous times during the transfer but they continued to transfer Resident #1 from the floor to the wheelchair and then from the wheelchair into bed. RN #1 identified he then assessed Resident #1 in bed, Resident #1 continued to yell out when turned and with range of motion to the left lower extremity. Interview with APRN #1 on 11/10/25 at 1:36 PM identified although Resident #1 is very impulsive, if the resident was yelling out in pain and showing signs and symptoms of pain immediately following the fall, RN #1 should have attempted to assess Resident #1 on the floor to rule out injuries prior to transferring Resident #1 back to bed. Interview with the Director of Nursing (DON) on 11/10/25 at 2:47 PM identified the staff should have

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 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 reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had sustained a fall, the facility failed implement interventions to ensure the resident was treated for severe pain. The findings include:Resident #1's diagnoses included muscle weakness, cognitive communication deficit, anxiety, depression and schizoaffective disorder (a mental health condition marked primarily by symptoms of schizophrenia such as hallucinations and delusions). The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating Resident #1 rarely or never made decisions regarding task of daily living and was dependent on staff for toileting, bed mobility and transfers. The Resident Care Plan dated 10/17/25 identified that Resident #1 was at risk for falls due to multiple risk factors including poor safety awareness and generalized weakness. Interventions directed a low bed, encouraging the resident to ask and wait for staff assistance for transfers and/or toileting, utilizing the call bell for assistance, therapy evaluation and treatment as needed and pharmacy and psychiatric medication reviews. The nurse's note dated 10/18/25 at 4:26 AM identified at 3:40 AM Resident #1 was observed lying in the middle of his/her room, reporting he/she transferred him/herself and ambulated unassisted, leading to the unwitnessed fall. The note identified Resident #1 was complaining of left hip pain and upon assessment, left hip erythema (redness of the skin) was present, no internal or external rotation was observed but limited range of motion was noted to the left lower extremity with complaints of pain ten, ten (10) out of ten (10), with movement. The note indicated Resident #1 was assisted back to bed, the Advanced Practice Registered Nurse (APRN) was notified and orders were obtained for a STAT (immediate) x-ray to the left hip and pelvis, Resident #1 was to remain on bedrest until the x-ray results were received and to apply ice to the left hip for ten (10) minutes every shift for three (3) days. Although the resident complained of severe pain following the fall at 3:40 AM, review of the October 2025 Medication Administration Record identified the application of ice to the left hip was not signed off as administered until the day shift, 7:00 AM to 3:00 PM, and although an order was available the as needed acetaminophen (a pain reliever) was not administered to Resident #1 until 12:20 PM (more than eight (8) hours following the fall) for a pain level of eight (8) out of ten (10). Review of the imaging report dated 10/18/25 identified Resident #1 had sustained an acute (new) left femoral (thigh bone) intertrochanteric fracture (a femur fracture just below the hip joint). The nurse's notes dated 10/18/25 identified Resident #1 was transferred to the hospital via ambulance at 12:45 PM and admitted for the left intertrochanteric fracture. The hospital documentation identified Resident #1 underwent a left femur intramedullary nailing (a surgical procedure where a metal rod is inserted into the center of the femur and is secured with screws at both ends) on 10/19/25. Interview with 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1, on 11/10/25 at 12:37 PM identified that on 10/18/25 at 3:40 AM she heard a noise from Resident #1's room and when she responded she observed Resident #1 sitting on the floor several feet from the bed and when Resident #1 saw her he/she began yelling dolor (pain in Spanish). LPN #1 explained the nurse aide, Nurse Aide (NA) #1, also responded and she then immediately notified the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1. LPN #1 identified although Resident #1 was anxious and yelling out in pain with any movement, RN #1 directed her and NA #1 to assist in standing Resident #1 prior to Resident #1 being assessed, and Resident #1 repeatedly yelled dolor during the three (3) person stand-pivot transfer back to bed. LPN #1 explained although Resident #1 had been yelling out in pain immediately upon the fall, which was abnormal for him/her, she did not medicate Resident #1 for pain prior to the transfer, stating it all happened so quick, and reported that once Resident #1 was back in bed she also did not medicate Resident #1 for pain, apply the ice prior to leaving her shift at 7:00 AM (more than three (3) hours later) or reassess Resident #1's pain. Interview with RN #1 on 11/10/25 at 1:11 PM identified when he responded to Resident #1's room on 10/18/25 following the fall, Resident #1 was yelling out and was in visible pain and he knew something was wrong. RN #1 explained Resident #1 was very anxious and wanted to get up, so prior to addressing the pain or assessing Resident #1, he directed LPN #1 and NA #1 in assisting him in standing Resident #1 to get Resident #1 back to bed. RN #1 identified Resident #1 was fighting against them, was very guarded, tense and yelled out in pain numerous times during the transfer and when he assessed Resident #1 in bed, Resident #1 continued to yell out when turned and with range of motion. RN #1identified he communicated his findings to the APRN he gave orders and LPN #1 should have applied the ice to the

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, clinical record reviews, facility policy and interviews, the facility failed to ensure a medication cart located in the hallway was locked and the medication was secured to prevent unauthorized access. The findings include:Observations on the A Wing on 11/10/25 at 12:15 PM identified a medication cart in the main hallway off the main entrance, pushed up against the left side of the hall, about half of the way down. The medication cart was noted to be unlocked with an open cup of apple sauce, one (1) pre-poured cup of nutritional supplement, a cell phone on top of the cart and the computer screen was observed to be open and unlocked, displaying resident information. Registered Nurse (RN) #2 was noted to emerge from a resident's room at 12:18 PM. The Director of Nursing (DON) was subsequently notified following the observations. Observations on the A Wing on 11/10/25 at 1:22 PM identified a medication cart in the main hallway off the main entrance, pushed up against the left side of the hall, about two-thirds of the way down. The medication cart was noted to be unlocked with an open cup of apple sauce, one (1) pre-poured cup of nutritional supplement, a cell phone on top of the cart and the computer screen was observed to be open and unlocked, displaying resident information. Multiple residents were observed walking by the open medication cart but did not approach the cart. RN #2 was noted to emerge from a resident's room at 1:27 PM. Interview and observations of the medication cart with RN #2 and the DON on 11/10/25 at 1:27 PM identified RN #2 explained she should not have left any of the above items on the top of the cart with the cart unlocked, unsecured and with the computer screen displaying resident identification. RN #2 indicated although she knows not to do so, there are ambulatory residents in the hallway, she was unable to explain why the medication cart was left the way it was twice in just over one (1) hour. The DON identified RN #2 should not have left items on top of the cart when the cart was unattended and both the medication cart and the computer screen should be locked at all times when the nurse steps away from it. Review of the Medication Administration policy (undated) directed, in part, that medications should be stored in a secure, locked area accessible only to authorized personnel and resident confidentiality is to be maintained by ensuring all medication records are kept private and secure.