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	08/12/2025

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 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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F 0600 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 review of the clinical record, facility documentation, facility policy and interviews for 1 of 6 residents (Resident #25) reviewed for abuse, the facility failed to ensure the resident was free from inappropriate touching by Resident #41, who had a history of inappropriate touching. The findings include: 1a. Resident #25 was admitted to the facility in April 2024 with diagnoses that included dementia, psychotic disturbance, mood disturbance, anxiety disorder, and major depressive disorder.The care plan dated 4/3/25 identified Resident #25 was involved in a resident-to-resident physical interaction (Resident #25 was inappropriately touched by Resident #41). Interventions included Resident #25 will be encourage not to engage in a kiss and hug with male peer. Offer psychiatric and social services support. The annual MDS dated [DATE] identified Resident #25 had severely impaired cognition and required setup or clean up assistance with bed mobility, transfer, and walk 150 feet. Additionally, Resident #25 had no physical and verbal behaviors directed toward others. The physician's order dated 7/29/25 directed the resident be independent with transfers and gait with rollator walker.The nurse's note dated 8/1/25 at 6:50 PM by the RN Supervisor (RN #4) identified Resident #25 was touched by Resident #41. RN assessment performed and APRN notified. The care plan dated 8/1/25 identified Resident #25 was involved in a resident-to-resident physical interaction. Resident #41 touched Resident #25 inappropriately. Interventions included resident will be seated with female peers not with male peers when participating in recreational activities. Offer psychiatric and social services support.The social services note dated 8/4/25 at 10:59 AM identified a wellness visit was done following an incident Resident #25 had with Resident #41. Resident #25 reports he/she recalled the incident but has no ill effects noted. Social service support and will remain involved as needed.The psychiatric APRN note dated 8/7/25 identified she was asked to see Resident #25 after an alleged incident with Resident #41. Resident #25 does not remember the incident. Resident #25 indicated he/she feels safe at the facility and feels comfortable around all his/her peers. Monitor behavior for depression, loss of interest in activities and isolation. b. Resident #41 was admitted to the facility in May 2024 with diagnoses that included Parkinson's disease with dyskinesia and anxiety disorder.The care plan dated 4/3/25 identified Resident #41 was involved in a resident-to-resident physical interaction. Resident #41 was witnessed kissing female peer (Resident #25). Interventions included offering psychiatric and social services support. RN assessment. Notify the physician and resident representative.The quarterly MDS dated [DATE] identified Resident #41 had intact cognition and had exhibited physical and verbal behavioral symptoms directed towards others. The reportable event form dated 8/1/25 identified Resident #41 was witnessed with arms around the waist of Resident #25. Residents were separated, Resident #25 was assessed by an RN, and Resident #41 was placed on 1:1 monitoring. The Administrator, police, APRN, psychiatric APRN, both power of attorneys were notified. The nurse's note dated 8/1/25 at 4:51 PM by RN #4 identified Resident #41 spoke with the psychiatric APRN via telehealth video conference. Psychiatric APRN felt Resident #41 was safe to come off 1:1 monitoring and to being monitored every 15 minutes. The care plan dated 8/1/25 identified Resident #41 was witnessed touching female peer inappropriately. Interventions included 1:1 monitoring until cleared by psychiatry and then every 15 minutes checks. Encourage resident to sit with male residents at recreation activities. Supervise during recreation activities. Psychiatric and social services follow up. The psychiatric APRN note dated 8/1/25 at 5:17 PM identified she was asked to see Resident #41 today for recent inappropriate sexual comments. Met with Resident #41 via telehealth. Resident #41 is not currently a danger to self or others. Nursing reports Resident #41 without further behavior at this time. This behavior for Resident #41 is not new. Resident #41 reports not making a comment. Discussed overall behaviors and what is not appropriate. Will discontinue 1:1 supervision and used every 15 minutes checks until seen by psychiatrist.The resident locator form dated 8/1/25 at 3:19 PM identified Resident #41 started on every 15 minutes monitor on 8/1/25 at 5:30 PM through 8/6/25 at 6:45 AM.A written statement by RN #4 dated 8/1/25 at 3:19 PM identified NA #4 reported to her that a few residents reported to NA #4 that Resident #41 was touching and cuddling Resident #25. RN #4 immediately went to the location which was A wing dining room and observed Resident #41 leaning into Resident #25's lap with his/her hand on Resident #25's thigh area rubbing and ultimately holding his/her hands. RN #4 indicated she separated the two residents immediately. RN #4 indicated she wheeled Resident #41 out of the dining room into the lobby area where the Administrator was and reported to the Administrator what was reported to her and what she observed. Resident #41 was placed on 1:1 monitoring

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #10) reviewed for falls, the facility failed to ensure that 2 staff members were present during care per the care card and physician's orders. The findings include: Resident #10 was admitted to the facility in February 2025 with diagnoses that included chronic obstructive pulmonary disease, urinary retention, and dementia.The quarterly MDS dated [DATE] identified Resident #10 had severely impaired cognition, was frequently incontinent of bowel, required a urinary catheter for bladder, and required substantial assistance with bathing, dressing, and transfers.The care plan dated 6/10/25 identified Resident #10 had a history of falls. Interventions included close/frequent observation due to poor safety awareness.Review of the clinical record identified Resident #10 was hospitalized from [DATE] - 7/16/25 for UTI and metabolic encephalopathy. A nurse's note dated 7/16/25 at 10:44 PM by RN #4 identified Resident #10 was aggressive and lashing out during bedtime care. RN #4 identified that Resident #10 had not exhibited aggressive behaviors previously and identified interventions would include 2 persons with all care and that the intervention had been added to the care card.Review of the RN supervisor shift report book for 7/16/25 identified multiple report notes written by RN #4 for Resident #10 which included that Resident #10 was to have 2 persons with care at all times. Review of the care card identified Resident #10 was a fall risk and required 2 persons with all care. A physician's order dated 7/17/25 directed to provide assistance of 2 with transfers and a rolling walker.A reportable event form dated 7/17/25, completed by RN #5 (7:00 AM - 3:00 PM RN Supervisor) identified Resident #10 had a witnessed fall at 9:30 AM. The form identified that NA #3 was attempting to transfer Resident #10 from his/her bed to a shower chair with the use of a rolling walker. The form further identified that during the transfer, NA #2 had not utilized a gait belt to assist and Resident #10's knees buckled and the resident was lowered to the floor by NA #3. The form identified Resident #10 had no injuries as a result of the fall and identified NA #3 was the only witness to the fall. RN #5 identified interventions to prevent future falls included use of a gait belt. Interview with RN #4 (3:00 PM - 11:00 PM RN Supervisor) on 8/12/25 at 9:00 AM identified she was called into assess Resident #10 following aggressive behaviors with the nurse aide at bedtime care. RN #4 identified Resident #10 had just been readmitted from the hospital earlier in the shift and had not exhibited aggressive behaviors previously but had a weeklong hospitalization due to a UTI. RN #4 identified that due to the change in behaviors, the hospitalization, and the resident's underlying dementia, she added 2 persons with all care to the resident's care card and also added the order for assist of 2 with rolling walker. RN #4 also identified that she also added the information to the RN supervisor shift report book. RN #4 identified that all nurse aides were responsible to review the care cards for all residents assigned to them as the care cards were a living document and often were changed or had new or additional interventions added for residents. RN #4 also identified that all RN supervisors coming onto shift were responsible to review for the prior 24 hours as well as to update the book with any changes as well. Interview with PT #1 (Director of Rehab) identified that in the last year, the facility had changed its gait belt policy to identify that facility staff were able to use discretion regarding whether or not to use a gait belt with transfers. PT #1 identified that she had not provided any in-service training to staff regarding transferring residents safety without the use of a gait belt and it was her practice, as well as all the therapists and assistants in her department, to always utilize a gait belt with any resident who required an assist of 1 or more. Interview with RN #5 on 8/12/25 at 9:47 AM identified she completed the investigation and reportable event form for Resident #10's witnessed fall on 7/17/25 at 9:30 AM. RN #5 identified that NA #3 was attempting to transfer Resident #10 from the bed to a shower chair when Resident #10 began to fall. RN #5 identified NA #3, who was positioned behind Resident #10, put her arms under Resident #10's armpits and lowered him/her to the floor. RN #5 identified that NA #3 reported she was the only staff member present at the time of the fall and had not utilized a gait belt during the transfer and based on this she added the gait belt as an intervention. RN #5 identified she had been employed at the facility for 3 months and had not received any training or in-services on when to use a gait belt, but she had worked at other facilities, and it was her practice to always use a gait belt for anyone who was a risk for falls. RN #5 also identified that she had been notified by multiple staff at the facility that use of gait belts were optional for all staff. RN #5 identified that the resident care card was typically reviewed by the nurse aides, but she reviewed the RN supervisor book every morning. Upon review of the notes entered by RN #4, RN #5 identified did not recall

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #6) reviewed for tracheostomy care, the facility failed to ensure that appropriate infection control practices were implemented during tracheostomy care. The findings include: Resident #6 was admitted to the facility in July 2024 with diagnoses that included myocardial infarction, epilepsy, and tracheostomy. A physician's order dated 9/11/24 directed to change disposable inner tracheostomy cannula everyday shift and as needed. The quarterly MDS dated [DATE] identified Resident #6 had severely impaired cognition, was dependent on staff assistance with eating, bathing, and toileting. The MDS also identified Resident #6 required tracheostomy care. The care plan dated 6/30/25 identified Resident #6 had a tracheostomy related to respiratory failure. Interventions included to provide tracheostomy care as ordered and maintain enhanced barrier precautions per facility protocol.An enhanced barrier precautions line list dated 8/6/25 identified Resident #6 was on enhanced barrier precautions (EBP) for a tracheostomy.Observation 8/12/25 at 11:50 AM directly outside of Resident 6's doorway identified a PPE cart with signage posted outside the room door which identified enhanced barrier precautions. The signage directed that everyone entering the room must clean their hands before entering and when leaving the room. The signage also directed that providers and staff must also wear gloves and a gown for high contact resident care activities including device care for tracheostomies.Observation of Resident #6's tracheostomy care beginning at 8/12/25 at 11:50 AM identified RN #5 and LPN #1 were standing inside the room at Resident #6's bedside wearing disposable gloves, and LPN #1 also wearing a disposable surgical mask. Both RN #5 and LPN #1 were without the benefit of gowns. LPN #1 identified she was going to begin to provide tracheostomy care and RN #5 identified she was assisting LPN #1. LPN #1 reached for Resident #6's tracheostomy straps. Prior to LPN #1 initiating care of Resident #6's tracheostomy and following surveyor inquiry related to EBP, LPN #1 and RN #5 identified they were aware that Resident #6 was on enhanced barrier precautions and were then observed dropping their gloves and utilizing hand sanitizer prior to exiting the room. RN #5 and LPN #1 were then observed donning new gloves and a disposable gown in the hallway and reentering Resident #6's room subsequent to surveyor inquiry. Observation at 11:52 AM identified LPN #1 used a bedside table to place the unopened sterile tracheostomy care and cleaning tray without wiping the table down or placing a barrier on the table. LPN #1 was observed touching multiple areas on the table including the underside of the table and then began to touch the suction machine located on Resident #6's night stand. After checking the suction machine, LPN #1 removed a newly opened suction tip from its packaging and touched the tip multiple times with the same gloved hands. At 11:55 AM, LPN #1 removed her gloves but was not observed performing hand hygiene initially. Subsequent to surveyor inquiry, LPN #1 proceeded to Resident #6's bathroom and used the sink to wash her hands with soap and water. At 11:58 AM, LPN #1 was observed opening the sterile tracheostomy care and cleaning kit and began to remove items from the kit including a sterile cup and lid and sterile gloves with her hands. LPN #1 was observed with her hands inside of the kit touching exposed portions of the sterile gloves. During this observation, RN #5 was positioned on the opposite side of Resident #6's bed and was not observed providing any instruction or direction to LPN #1. LPN #1 identified that the items she removed from the kit were to be used sterile and subsequent to surveyor inquiry identified that the items were in fact no longer sterile due to the way they were removed. At 12:05 PM, RN #5 identified she would attempt to locate RN #1 (IP nurse), to assist LPN #1, and exited the room. LPN #1 then identified that while she had performed tracheostomy care and utilized PPE and the sterile cleaning kit previously, she was nervous and frozen due to observation by this surveyor. Observation at 12:08 PM identified RN #1 entered the room and was notified by LPN #1 that she would be unable to complete the tracheostomy care due to being nervous. RN #1 identified she would assist LPN #1 with the tracheostomy care but that a new tracheostomy care and cleaning kit would need to be used due to the previous kit no longer being sterile. RN #1 exited the room and returned at 12:10 PM with a new kit along with being gowned and gloved prior to entering the room. RN #1 and LPN #1 were observed from 12:10 PM - 12:35 PM performing tracheostomy care utilizing a new sterile kit for Resident #6. During the entirety of observation, LPN #1 required substantial direction which included step by step instruction from RN #1 to complete the treatment. Interview with RN #1 at 12:36 PM immediately following the tracheostomy care observations identified that she was unsure what happened and that she was not aware of any issues related to LPN #1 performing tracheostomy care in the