

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075327	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Apple Rehab Mystic		STREET ADDRESS, CITY, STATE, ZIP CODE 28 Broadway Mystic, CT 06355	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826</p> <p>Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who left the facility without informing the staff, the facility failed to conduct quarterly elopement assessments in accordance with the facility policy. The findings include:</p> <p>Resident #1's diagnoses included hemiparesis following a stroke, depression and anxiety.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had some short- and long-term memory recall deficits, had not exhibit behaviors of wandering or elopement and self-propelled in a wheelchair.</p> <p>The Resident Care Plan dated 7/25/24 identified Resident #1 was depressed due to restricted physical activity.</p> <p>Interventions directed to report changes in mental status, psychiatric visits as needed, administer medications as ordered, and offer activities of interest.</p> <p>The nurse's note dated 9/29/24 at 11:53 AM identified when the charge nurse attempted to pass the 9:00 AM medications she was unable to locate Resident #1. The note indicated Resident #1 was not located in the facility, the sign-out book was not filled out that Resident #1 was out, a family member who Resident #1 goes out with often was contacted, and Resident #1 was not with the family member. The note identified the Nursing Supervisor, Director of Nursing, and police were notified.</p> <p>The nurse's note dated 9/29/24 at 12:05 PM identified Resident #1 was found by the police near the facility.</p> <p>The nurse's note dated 9/29/24 at 9:36 PM identified when attempted to place a wanderguard on, Resident #1 protested, became very belligerent, began using profanity and strongly disagreed with the placement of the wanderguard bracelet.</p> <p>Review of the clinical record identified the last Elopement Risk Assessment was conducted on 1/3/24 which identified Resident #1 was not at risk of elopement and the next one (1) was conducted on 9/29/24 which placed Resident #1 at risk and a wandergurad was initiated.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Elopement Risk Assessments and Quarterly Nursing Assessments identified</p> <p>the facility failed to follow their established policy and consistently conduct elopement assessments on an additional eighteen (18) of fifty-one (51) residents to determine if the residents were at risk for elopement.</p> <p>Interview with Resident #1 on 10/22/24 at 12:00 PM identified he/she was aware his/her family member was not coming to pick him/her up and he/she let him/herself out the front door to go to the gas station to purchase cigarettes. Resident #1 stated that this was the first time he/she left the facility without a family member.</p> <p>Interview with the Administrator on 10/23/24 at 2:00 PM identified Resident #1 was seen on video footage exiting the building at 9:30 AM after a visitor had entered the building before the door completely closed. The Administrator indicated all the building doors have codes to exit the building. The Administrator stated the police found Resident #1 at the gas station located five hundred (500) feet from the building. The Administrator identified the facility policy was that an elopement assessment was to be done quarterly, and the facility had not followed its policy.</p> <p>Review of the facility policy Elopement Risk directed all residents are evaluated for risk of elopement on admission, readmission, quarterly, with a change in condition and elopement attempt.</p>