

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 08/21/2025
NAME OF PROVIDER OR SUPPLIER Apple Rehab Mystic		STREET ADDRESS, CITY, STATE, ZIP CODE 28 Broadway Ave 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)
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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the State Agency was notified timely of an allegation of abuse after staff were aware and documented the incident in the medical record. The findings include:Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the State Agency was notified timely of an allegation of abuse after staff were aware and documented the incident in the medical record. The findings include: A. Resident #1 was admitted with diagnoses that included bipolar disorder (manic episodes with high energy, decreased need for sleep and loss of touch with reality alternating with depression). A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10 (indicative of moderate cognitive impairment) and was independent for transfers and ambulation with a walker. The Resident Care Plan (RCP) dated 5/1/2025 identified Resident #1 was impulsive and not always able to control his/her behavior directing anger at staff and residents that sometimes resulted in verbal and physical aggression. Interventions directed to assist resident to another area if mood change was observed, and spend a few minutes in quiet conversation until anger subsides. B. Resident #2 was admitted with diagnoses that included stroke and opioid dependance. A quarterly MDS assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 (indicating he/she was alert and oriented) and was independent with transfers and ambulation with a walker. A RCP dated 4/2/2025 identified Resident #2 had negative feelings regarding self and social relationships. Interventions directed to encourage self-control and problem-solving skills and direct energies into stress reducing behaviors. A social services note dated 6/30/2025 at 3:45 PM written by SW #1 identified Resident #1 was noted walking up near the social worker's office when he/sheengaged in a verbal confrontation with Resident #2 that included threats of physical violence. The two residents were separated, and Resident #1 went into the social worker's office. Initially Resident #1 was highly irritated but eventually was able to be diffused and was walked back to his/her room. Shortly thereafter, Resident #1 came back to the social worker's office, cursing and making threats of violence. The Administrator and ADNS intervened with the ADNS escorted Resident #1 to his/her room, distracting Resident #1 through conversation. Social Services note for Resident #2 dated 6/30/2025 at 3:53 PM identified Resident #2 when a verbal altercation occurred, the residents were separated, and Resident #2 went out on the patio and denied any wrongdoing in the incident. A nursing note for Resident #1, dated 6/30/2025 at 8:09 PM written by LPN #3 identified Resident #1 was observed screaming and swearing at other residents and staff at the beginning of the shift. Resident #1 was evaluated by psychiatric APRN with new orders obtained. A psychiatric APRN #1 note for Resident #1, dated 6/30/2025 at 4:01 PM written by APRN #1 identified she evaluated Resident #1 due to an alleged verbal aggression. Resident #1 was anxious and irritable and had some difficulty decreasing his/ her irritability and anxiety. A PRN (as needed) and a one-time dose of Trazadone (anti-depressant medication also used to treat anxiety) 50 milligrams (mgs) were ordered. A psychiatric APRN #1 note for Resident #2, dated 6/30/2025 at 4:50 PM identified she evaluated Resident #2 after the indicated, and Resident #2 was pleasant and denied initiating the incident. Resident #2 reported feeling safe at the facility. Interview and medical record review with SW #1 on 8/20/2025 at 12:50 PM identified that on 6/30/2025 she observed Resident #1 following Resident #2 into the lobby area in front of her office. Resident #1 was yelling, both residents called each other b-tch and Resident #1 responded, you know what happened the last time. SW #1 identified Resident #1 was referring to a previous resident to resident incident on 6/14/2025 when Resident #1 slapped Resident #2 during a verbal altercation, and Resident #1 told Resident #2 this would end the same way, with Resident #1 slapping Resident #2, if the argument continued. There was no physical contact between the residents and they were separated. SW #1 stated a short time later Resident #1 returned to her office, was yelling and swearing, and threatened to hit her. The former Administrator and the ADNS (currently the DON) responded and assisted to calm Resident #1. SW #1 could not recall if she told the Administrator or the ADNS about her observation of the initial resident to resident verbal aggression and physical threat that occurred prior to this incident. Interview and medical record review with RN #2 on 8/21/2025 at 9:40 AM identified she was the supervisor on 6/30/2025 but she could not recall that she was informed about the resident-to-resident event on</p>		