STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Ave Mystic, CT 06355

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy and procedures, review of facility documentation, and interviews for one of two sampled residents (Resident #57) reviewed for an allegation of mistreatment, the facility failed to ensure that the MD/APRN was notified of a bruise of unknown origin in a timely manner. The findings include:Resident #57's had diagnoses that included dementia, anxiety and osteoarthritis of knee.The quarterly MDS assessment dated [DATE] identified Resident #57 had severely impaired cognition, had no behaviors and required maximal assistance with personal hygiene, transfers, dressing, bed mobility and was dependent for toileting hygiene. The assessment further identified Resident #57 was dependent on the staff with the use of a wheelchair and ambulation was not attempted. The assessment identified Resident #57 had no wounds or skin problems.The care plan dated 2/18/26 identified Resident #57 was at risk for skin breakdown related to decrease mobility and incontinence with interventions that included Geri-sleeves to be worn on arms as tolerated, gentle handling during transfers and care procedures, and to inspect skin when providing care for sign/symptoms of breakdown.The reportable event form dated 4/6/26 at 2:30 PM completed by the ADNS (RN #2) identified staff reports observation of bruising. The report further identified 2 bruise/purpura observed to right and left forearms, the resident denied pain and knowledge of its origin. In addition, the report identified APRN #1 was notified on 4/6/26.Review of the nursing progress note failed to identify any documentation that the APRN/MD was notified of the reported bruising identified on 4/6/26.The APRN's progress note dated 4/13/26 at 9:49 AM written by APRN #1 identified bruising to bilateral forearms and apparently these bruises were noted last week by the nursing staff, however, it was not brought to her attention until she received a phone call on Friday (4/10/26). The note further identified she was not back at the facility until Monday, and she advised them she would assess the resident then as long as there were no acute issues, but that if the physician came on Saturday, she advised them to also have the physician assess. APRN #1's note further identified nursing states that Resident #57 had a fall on Saturday with no sustained injuries but that the bruising predated that fall. The note further identified the physical examination of the skin which noted bilateral forearm bruising with dark red to maroon in color. Interview with the ADNS (RN #2) in the presence of the Regional Clinical Nurse (RN #7) on 5/5/26 at 12:38 PM identified he had completed the incident report on 4/6/26 and following any identification of a bruise of unknown origin the MD/APRN should be notified. RN #2 identified he had notified APRN #1 of the bruising via text or phone call and provided a text message sent to APRN #1 on 4/9/26, however, he was unable to identify that APRN #1 was notified of the bruising on 4/6/26 as stated on the reportable event form. The DNS then joined the interview, and they identified the APRN/MD should have being notified at the time when the bruising was identified and not 72 hours laterInterview with APRN #1 on 5/6/26 at 9:15 AM identified she is at the facility on Monday and Wednesday and she is on call daily until 6:00 PM and she was not made aware until Friday (4/10/26) of the bruising, in fact the resident told her that somebody hurt him/her and she then reported it to nursing. APRN #1 identified that nursing had concern whether the area was purpura or petechiae, so she had ordered blood work which she (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed, and the area is in fact a bruise.Review of the Change in Resident Condition/Family/MD Notification policy and procedure identified when there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident that the resident's attending physician shall be notified, if the attending or covering physician is not available, the medical director or his associate shall be called and the nurse will document in the nurse's notes that the physician and family or responsible party have been notified of the change in condition.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy and procedures, and interviews for one of two sampled residents (Resident #57) reviewed for an allegation of mistreatment, the facility failed to ensure that a thorough investigation was completed regarding a bruise of an unknown origin. The findings include:Resident #57's had diagnoses that included dementia, anxiety osteoarthritis of knee.The quarterly MDS assessment dated [DATE] identified Resident #57 had severely impaired cognition, had no behaviors and required maximal assistance with personal hygiene, transfers, dressing, bed mobility and dependent with toileting hygiene. The assessment further identified Resident #57 was dependent on the staff with the use of a wheelchair and ambulation was not attempted. The care plan dated 2/18/26 identified Resident #57 was at risk for skin breakdown related to decrease mobility and incontinence with interventions that included Geri-sleeves to be worn on arms as tolerated, gentle handling during transfers and care procedures, and to inspect skin when providing care for sign/symptoms of breakdown.The reportable event report dated 4/6/26 at 2:30 PM identified staff reported bruising to Resident #57's arms. The report further identified 2 bruises observed to the right and left forearms, the resident denied pain and knowledge of its origin. In addition, the report identified there were no witnesses.APRN #1's progress note dated 4/13/26 at 9:49 AM identified bruising to bilateral forearms was noted last week by the nursing staff. The note further identified APRN #1 was notified on Friday (4/10/26) and she saw the resident on 4/13/26 when Resident #57 told APRN #1 that somebody hurt him/her and due to the resident's significant dementia, the resident could not give her any other information beyond that. The note further identifies the physical examination of the skin which noted bilateral forearm bruising with dark red to maroon in color.The reportable event report dated 4/13/26 at 10:00 AM identified Resident #57 reported bruising noted on arm on 4/6/26 was caused by someone hurting him/her. The report further identified an injury of bruising on bilateral arm, no pain or acute distress.Interview and review of the clinical record with the ADNS (RN #2), and the DNS in the presence of the Regional Clinical Nurse (RN #7) on 5/5/26 at 12:45 PM identified statements were not obtained when the bruises were first identified on 4/6/26. The DNS identified statements should have being collected from staff who cared for Resident #57 24 hours prior to the identification of the bruise to identify how the bruise had occurred. The DNS identified that statements were not obtained until when the resident reported on 4/13/26 that somebody hurt him/her. The DNS further identified there was a delay in the investigation process, hence, why she identified on the 4/13/26 reportable a follow-up of the 4/6/26 reportable which she should have thoroughly investigated 4/6/26 incident separately. She then indicated because the investigation was not completed on 4/6/26 when she interviewed staff following the 4/13/26 report she included who cared for the resident during the 4/6/26 reported incident. The DNS further identified they had no excuse as to why 4/6/26 reported bruise was not thoroughly investigated, and a care plan was put in place to prevent recurrence. She identified that the in-service was not started until 4/14/26 and the care plan was updated to include the interventions that were initiated on 4/14/26 until 4/21/26, which should have been done at the time of the 4/6/26 reported incident. RN #2 identified he was reviewing the 4/6/26 reportable event when he realized the post assessment monitoring was not done so he then initiated the assessment form, assessed the area and wrote a note, which should have done early instead of 72 hours after the incident was reported. Interview and review of the clinical record with APRN #1 on 5/6/26 at 9:15 PM failed to identify that Resident #57 was ever on any blood thinner. APRN #1 identified the areas identified on Resident #57's bilateral forearm are bruises as they were perfectly symmetrical. She further identified that based on the laboratory work results, the areas identified on the resident bilateral arms were not purpura or petechia but in fact bruises. APRN #1 identified the bruises she observed on 4/13/26 on Resident #57's bilateral forearms were not new but appeared a few days (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	old.Review of the Accident/Incident/(Resident) Reportable event policy identified any injury of unknown origin will be investigated and all staff that cared for the resident 24 hours prior to the observation of the injury will be interviewed, ensuring all statements are documented. The policy further identified is unable to determine a cause through the investigation, documenting the investigation as inconclusive. The Abuse policy identifies all allegations will be thoroughly investigated, and appropriate action will be taken. The policy further identifies staff must identify and report any suspicious bruising, patterns of injury, or behavioral changes that may indicate abuse. Any staff member witnessing or suspecting abuse must immediately report it to a supervisor who should then immediately notify the DNS, and the administrator. The policy identifies the investigation will include interviews with all witnesses, including the accused, interviews with any individuals with relevant information, signed and dated statements from all parties involved and review of the accused staff member's employment record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policies/procedures and interviews for one sampled resident (Resident #57) found with bruises of unknown origin, the facility failed to ensure the bruising was assessed according to acceptable standards of practice and the facility's policy/procedure and for one sample resident (Resident #12) reviewed for surgical wound care, the facility failed to ensure that a surgical wound treatment was provided in a timely manner. The findings include: Resident #57's had diagnoses that included dementia, anxiety osteoarthritis of knee. The quarterly MDS assessment dated [DATE] identified Resident #57 had severely impaired cognition, required maximal assistance with personal hygiene, transfers, dressing, and bed mobility, and was dependent on staff for toileting hygiene and wheelchair mobility. The care plan dated 2/18/26 identified Resident #57 was at risk for skin breakdown related to decreased mobility and incontinence with interventions that included Geri-sleeves to be worn on arms as tolerated, gentle handling during transfers and care procedures, and to inspect skin when providing care for signs/symptoms of breakdown. The reportable event report dated 4/6/26 at 2:30 PM completed by RN #2 (ADNS) identified staff reported Resident #57 had bruises on the right and left forearms, the resident denied pain or knowledge of its origin. The reportable event report did not contain a description of the bruises inclusive of color, the presence or absence of swelling, what the skin around the bruise looked like, location and measurements of the bruises. The clinical record also failed to identify the above information for the date that the bruises were first observed. Interview and review of the clinical record on 5/5/26 at 12:45 PM with the RN #2, the DNS and the Regional Clinical Nurse (RN #7) identified the clinical record failed to contain documentation of a thorough assessment of the bruises to the resident's bilateral arms found on 4/6/26. RN #2 identified that he was responsible for completing the assessment and writing the note at the time the bruises were reported to him. He further noted that he had not completed a thorough assessment of the bruises at the time they were found and noted that he documented an assessment of the bruises on 4/9/26 (3 days after the bruises were reported). In addition, he noted that the facility practice/procedure is that the assessment of the bruise should include details about the bruise such as location, measurements of the bruise, color, notification of MD/APRN and family. On further review of the clinical record on 5/5/26 at 12:45 PM with the RN #2, the DNS and RN #7 identified that following changes in condition/injuries, post-accident/incident forms are initiated and completed each shift for 72 hours. This form would include continued assessments of the injury/skin condition. Further review also failed to identify a treatment order. RN #2 further identified that he had not notified the APRN or physician at the time the bruising was reported. The DNS and RN #7 identified that the post-accident/incident assessment should have been implemented on 4/6/26 when the bruising/incident was first identified instead of on 4/9/26 and noted that the accident/incident 72-hour monitoring/assessment is completed to note changes and/or improvements in the resident's condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Change in Resident Condition/Family/MD Notification policy and procedure identified when there is a significant change in the condition of a resident's physical, mental or emotional status, or in the event of an accident involving the resident that a RN assessment will be conducted and a nurse will document in the nurse's notes that the physician and family or responsible party have been made aware of the change in condition. Resident #12 was admitted to the facility on [DATE] with diagnoses that included a displaced bicondylar fracture of the left tibia and an encounter for other orthopedic aftercare. The admission MDS assessment dated [DATE] identified Resident #12 had intact cognition and required extensive assistance with toileting, personal hygiene, bed mobility, transfer. The RCP dated 3/18/26 identified Resident #12 as being at risk for skin breakdown, which could affect the resident's health condition and potentially contribute to an alteration in skin integrity. The care plan interventions directed staff to consult with the wound care nurse specialist as ordered, inspect the skin during care for signs and symptoms of skin breakdown, provide wound treatment per physician orders, and keep the skin clean and dry with the application of barrier cream. The nurse's note dated 4/15/26 at 12:55 PM indicated Resident #12 was out of the facility for an orthopedic appointment and did not return. The note further identified the resident was sent to the hospital for further evaluation. The clinical record identified Resident #12 was out of the facility from 4/16/26 through 4/24/26. The hospital Discharge summary dated [DATE] identified Resident #12 was discharged with exposed orthopedic hardware. The discharge summary further indicated that wound care to the left lower leg was to include applying Xeroform (yellow gauze) to the incision, securing it with kerlix, and applying an ACE wrap with gentle compression daily or as needed when soiled. The nurse's notes dated 4/25/26 identified Resident #12 was readmitted to the facility at 12:20 PM and had been treated in the hospital for an infection of the left lower leg and for a revision of the left lower tibia fracture. The notes also indicated that the resident had been treated for a pulmonary embolism during the hospitalization, and Eliquis (an anticoagulant) was newly prescribed. Review of the physician's orders from 4/25/26 through 4/27/26 failed to identify Resident #12 had an active treatment order for the left lower leg surgical wound. The physician's order dated 4/28/26 directed staff to cleanse the left lower tibia with warm, soapy water, without scrubbing, and to pat the area dry. The order further directed staff to apply Xeroform (yellow gauze) to the incision, secure it with Kerlix wrap, and apply an ACE wrap for gentle compression once daily. Additional instructions indicated to not apply lotions or ointments to the surgical site. Review of the Treatment Administration Record (TAR) from 4/25/26 through 4/29/26 identified that the first documented wound treatment to Resident #12's left lower leg occurred on 4/29/26, which was three days after the resident's readmission on [DATE]. Interview with RN #2 (wound nurse) on 5/5/26 at 10:55 AM identified he is responsible for weekly wound monitoring, including the monitoring of surgical wounds, and noted that the wound specialist (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	typically does not monitor surgical wounds because the surgeon is responsible for directing wound care for those wounds. He further identified that the admitting nurse is responsible for ensuring that treatment orders are in place and for following the wound care instructions in the hospital discharge summary. Upon reviewing Resident #12's treatment record, he identified that there had been no wound treatment orders in the physician's orders when the resident was readmitted on [DATE]. He further identified that wound care for the surgical wound on the left lower leg tibia should have been implemented on the day of admission and not three days later. Interview with the DNS on 5/5/26 at 11:15 AM identified that the surgical wound care instructions in the discharge summary were to be followed and transcribed into the physician's orders on the day of admission. She identified that the admitting nurse was responsible for ensuring that the treatment for the surgical wound was entered into the physician's orders. Although she could not provide a reason why there had been no treatment order for Resident #12's left lower leg surgical wound, she identified that she would have expected the admitting nurse to ensure that a treatment order was in place and that RN #2 would also have reviewed Resident #12's record to verify that the surgical wound treatment had been implemented. Interview with RN #1 (admitting nurse) on 5/6/26 at 2:20 PM identified that the admitting nurse is responsible for reviewing the hospital discharge summary upon admission and for following all instructions contained in the summary, including wound care. She identified that she admitted Resident #12 on 4/25/26 and observed that the resident had an immobilizer on the left lower leg and a dressing in place on the left lower tibia. She reported that she thought the surgeon wanted the dressing to remain in place until the resident's followˆup visit with the surgeon. She further identified that she missed the wound care instructions in the discharge summary and acknowledged that the treatment should have been initiated on the day of the resident's admission. The facility's Wound and Skin Care Protocol established that the facility would provide a highˆquality resident care and support positive clinical outcomes by maintaining skin integrity and promoting wound healing through the consistent use of an evidenceˆbased skin and wound care protocol.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, review of clinical records, review of facility policies/procedures and interviews for three sampled residents (Residents #5, #31, #57) reviewed for accidents and/or smoking, the facility failed to ensure appropriate supervision and monitoring to prevent smoking in the facility, failed to ensure the wheelchair leg rests were in place to prevent a fall and failed to ensure equipment was maintained to prevent a fall from a shower chair. The findings include: Resident #5's diagnoses included hemiplegia and hemiparesis following cerebral infarction, occlusion and stenosis of the left carotid artery, and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #5 was severely cognitively impaired, had no behaviors, required substantial/maximal assistance with bed mobility, and transfers, required total assistance for dressing and personal hygiene. The assessment further identified that the resident did not ambulate and utilized a wheelchair for mobility. The care plan dated 11/19/25 identified Resident #5 was at risk for falls related to multiple risk factors with interventions that included rehabilitation screen for safe transfers, patient reeducation to use call bell for assistance, and nonskid slipper socks. The APRN note dated 12/15/25 identified Resident #5 fell from a shower chair and sustained a skin tear to the right elbow. The facility Reportable Event report dated 12/15/25 identified that during Resident #5's shower, the shower chair collapsed causing Resident #5 to strike his head, posterior trunk, and sustain a skin tear to the right elbow. The report did not identify interventions regarding shower chair use and did not identify that the shower chair was inspected. Interview with APRN#1 on 5/6/26 at 8:00 AM identified she was present when the shower chair broke. Resident #5 can tend to be behavioral however during the time leading up to and when the chair broke Resident #5 was very calm and there was no moving around or exhibiting any out of the ordinary behaviors at the time. APRN#1 further identified she was able to assess the resident following the witnessed fall and that he/she suffered a skin tear on the right elbow. Interview with the Maintenance Director on 5/7/26 at 12:15 PM identified the maintenance department does not complete regular inspections or maintenance on the shower chairs. They would intervene when a broken issue or repair issue is brought to their attention. There is a log kept for Hoyer lifts and wheelchair scales but not shower chairs. Interview with the Rehabilitation Director on 5/7/26 at 12:30 PM identified that the rehabilitation department does not do regular inspections of shower chairs for the facility. The only shower chair that they utilize is one that they work with residents on in the rehabilitation area. Interview with NA #2 on 5/8/26 at 2:27 PM identified she was with Resident #5 when the shower chair broke. The shower had been completed and APRN #1 had come into the shower room to assess (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident. The shower chair was made of PVC (Polyvinyl Chloride), and it broke at the seams of where it was put together. NA #2 identified that although, she didn't think Resident #5 had been severely hurt it scared her more than anything at what the outcome could have been. Interview with the DNS on 5/7/26 at 12:45 PM identified she completed the investigation for the fall from the shower chair. She could not identify any root cause of why the shower chair broke and identified it as a freak accident. Interview with the Administrator on 5/8/26 at 12:30PM identified she could not locate the age of the shower chair that broke on 12/15/26. There were no receipts of it found. She could only locate the receipt of the purchase of a new shower chair following the incident on 12/15/26. There is no way to tell how old the shower chair was at the time of the accident. Review of the policy for Accident and Incidents directed the DNS or designee to review to determine of any potential risks and interventions that need to be put into place. Review of the policy for Falls directed complete an Accident and Incident report for each fall. Obtain statements for every fall event. Resident #31 was admitted to the facility April 2025 with diagnoses that asthma, opioid dependence, peripheral vascular disease, and nicotine dependence (cigarettes). Physician's progress note dated 4/2/25 at 8:30 AM identified Resident #31 was admitted to the facility with nicotine dependence and indicated there were no changes to management at that time. The initial care plan dated 4/3/25 identified Resident #31 had a substance use disorder related to nicotine use and was actively smoking in the community prior to admission to the facility and indicated Resident #31 had been told and understood the facility was non-smoking and that Resident #31 agreed to not have any smoking materials in his/her possession. Interventions directed to offer a nicotine patch, gum or lozenges, provide resident with smoking cessation materials if requested and provide a copy of the facility's smoking policy. Nursing progress note dated 4/20/25 at 12:13 AM identified Resident #31 admitted to smoking a cigarette in his/her room after staff noted the smell of cigarette smoke in the hallway near Resident#31's room. The note indicated that a room search produced a lighter and Resident #31 was educated on the non-smoking policy. Nursing progress note dated 4/20/26 at 6:54 AM identified Resident #31's sister was educated on the non-smoking policy as she takes Resident #31 out of the facility frequently and was the source of the cigarette. Administrator note dated 4/21/25 at 1:28 PM identified Resident #31 was provided education on the smoking policy, and he/she signed the smoking policy agreement. The admission MDS assessment dated [DATE] identified Resident #31 had moderately impaired cognition, felt down, depressed or hopeless, little interest or pleasure in doing things, and felt tired or had little energy nearly every day of the previous 14 days, required set up or clean up assistance with eating, oral hygiene and utilized a walker for mobility and was independent with transfers and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobility. Physician's progress note dated 5/2/25 at 4:45 PM identified Resident #31 was seen for a regulatory visit and indicated a diagnosis of nicotine dependence with no changes made to the management of the condition. The care plan focus added 11/6/25 identified Resident #31 had a prohibited item violation with interventions to perform room and package search with resident's consent, provide resident with psychiatric and social work and encourage resident to immediately report any cravings for illicit substances. Social Services progress note dated 11/6/25 at 3:16 pm identified Resident #31 had a lighter and cigarette butt confiscated the day before by staff and indicated Resident #31 had denied the occurrence. Social Services progress note dated 11/7/25 at 3:02 PM identified Resident #31 admitted to having a cigarette and lighter. He noted it was without the family member's permission when out on leave of absence. The progress note further indicated that the family member was informed of the incident. Review of Resident #31's clinical record and facility documentation (A&Is) for April 2025 through May 2026 failed to identify any monitoring for prohibited items or follow up with smoking cessation/education and failed to identify any A&Is for the April and November 2025 cigarette incidents. Observation of Resident #31 on 5/4/26 at 11:00 AM identified Resident #31 in the resident bed propped up on pillows and in pajamas. Resident #31's room smelled of cigarette smoke, although there was no visible haze. Resident #31 had the resident room window open. There was a smoke detector on the ceiling inside of the resident room, but no smoking paraphernalia was observed. Interview with Resident #31 on 5/4/26 at 11:12 AM identified Resident #31 smoked cigarettes when out of the facility and indicated that sometimes the smoke smell stays on the resident's clothing when returning to the facility but Resident #31 could not identify if he/she had left the facility that morning and did not answer the direct question of whether or not a cigarette had been smoked that morning. Observation of Resident #31's room on 5/4/26 at 2:04 PM identified a cigarette smell in the room with an observation of the window being open with a slight breeze. Upon opening the bathroom door, there was a strong smell of cigarette smoke with slight haziness noted in the bathroom. There was no smoking paraphernalia observed by this surveyor. Observation with RN #9 (assigned to Resident #31) on 5/4/26 at 2:08 PM of Resident #31's room and bathroom identified the room, and bathroom smelled of cigarette smoke. RN #9 looked through bathroom trash and did not find any smoking paraphernalia. Interview with the Administrator and the DNS on 5/4/26 at 2:13 PM identified they were aware of Resident #31's smoking when out of the building. Interview with the Administrator on 5/4/26 at 3:10 PM identified Resident #31 surrendered a lighter and a cigarette and indicated obtaining items from a family member (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Ave Mystic, CT 06355

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing progress note dated 5/4/26 at 3:26 PM identified Resident #31 was questioned regarding smoke noted in the resident room and indicated Resident #31 surrendered cigarettes and a lighter. Social Services progress note dated 5/5/26 at 8:03 AM identified Resident #31 refused a referral to a smoking facility, admitted smoking in the facility, and was educated on the facility being a non-smoking facility. Interview with the Maintenance Director on 5/5/26 at 8:54 AM identified he had been in the director position for approximately a year and indicated he placed a smoke detector in Resident #31's bathroom. The Director indicated that Resident #31 identified the ability to smoke outside at a previous facility. Interview with the DNS on 5/5/26 at 11:15 AM identified she worked at the facility as a supervisor since March 2025 and as the DNS since November 2025 and indicated that she recalled some conversation regarding Resident #31 smoking in the facility but was unable to recall specifics. The DNS identified that she did not complete an A&I nor did she investigate or report the smoking incidents from April or November 2025. Interview with the Administrator on 5/6/26 at 12:12 PM identified that when a resident is found smoking or with smoking items, an incident report should be completed, and progressive monitoring should be implemented. Subsequent to surveyor inquiry, the facility implemented a check-off sheet for Resident #31 to be checked for prohibited items when returning from LOA. The Administrator identified that she was not aware of the previous incidents of smoking in the facility and that the supervision should have been implemented sooner. Smoking policy identified the facility was a smoke-free environment for employees, Residents, and visitors. The policy identified smoking as the lighting, smoking or carrying of a lighted cigarette, pipe or cigar and includes the use of smokeless tobacco products such as e-cigarettes and vaping materials and any similar type of products. The facility policy for prohibited items in the environment identified that violations of the prohibited items policy may result in measures to increase the level of supervision to maintain a safe environment, up to and including involuntary discharge at the discretion of administration. The prohibited items list identified that use, distribution, or possession of cigarettes, cigars, pipes, e-cigarettes, vapes, vape liquids, lighters, matches, or other fire sources. The facility policy for prohibited items violation identified that if a resident is found to be in possession of any substances indicated as prohibited items, an accident and incident (A&I) report will be completed for each prohibited item violation and identified the resident's care plan will be updated to reflect current interventions. The policy identified that the facility implements progressive measures to increase the level of supervision to maintain a safe environment and indicated progressive measures such as: Resident may be provided with education/re-education Resident may be asked to consent to random supervised room/package/person searches (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident may be placed on increased frequency of checks, increased monitoring or supervision, including 1:1 observation Resident may be asked to consent to a psychiatric evaluation, if applicable Modification of leave of absence orders. Notification of local law authorities Issuance of an involuntary emergency discharge notice. Resident #57's had diagnoses that included dementia, anxiety osteoarthritis of knee. The quarterly MDS assessment dated [DATE] identified Resident #57 had severely impaired cognition, had no behaviors and required maximal assistance with personal hygiene, transfers, dressing, bed mobility and dependent with toileting hygiene. The assessment further identified Resident #57 was dependent on staff with wheelchair mobility. The care plan dated 2/18/26 identified Resident #57 was at risk for falls due to multiple risk factors with interventions that included, have commonly used articles within easy reach, provide lit, clutter free environment and physical and occupational therapy screen to help increase strength and endurance. The facility's accident and incident report dated 4/11/26 at 12:00 PM identified Resident #57 was in the dining room and slid from the wheelchair to the floor. The report noted Resident #57 had no injuries and there were no witnesses. The fall scene investigation documentation dated 4/11/26 identified the root cause of the fall was lack of footrests on the wheelchair, and the intervention to prevent future falls was to ensure footrests are in place on the wheelchair. RN #1's progress note dated 4/11/26 at 12:18 PM identified Resident #57 was found sitting on the floor of the dining room, directly in front of his/her wheelchair and RN assessment showed no change to the skin, denial of pain, range of motion at his/her baseline and staff assist to return resident to his/her wheelchair. Interview with the Director of Rehabilitation (OT #1) on 5/5/26 at 12:00 PM identified Resident #57 does not self-propel so he/she would need the footrest/leg rest in place when transported by his/her wheelchair. OT #1 indicated on evaluation after the fall identified resident was noted to not have the footrest/leg rest on the wheelchair at the time of the fall. She further identified the purpose of the footrest for Resident #57 is for support and keeping the resident upright, given that the resident has poor posture he/she would need the footrest on while seated in the wheelchair. When asked if the fall would have been prevented if the footrests were in place, OT #1 responded that it is less likely Resident #57 would have slid/fallen from the wheelchair. Interview with the DNS in the presence of the ADNS and the Regional Clinical Nurse (RN #7) on 5/5/26 at 12:38 PM identified Resident #57 slid out of his/her wheelchair when he/she was trying to pick something up. The DNS further identified that the footrest/leg rest was not in place and the resident should have had the footrest in place on the wheelchair while in the wheelchair and transporting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #2 on 5/6/26 at 1:45 PM identified she was made aware that Resident #57 had fallen from the wheelchair because the resident did not have the footrest/leg rests in place. NA #2 further identified Resident #57 is unable to self-propel in the wheelchair, so the footrest/leg rests needed to be in place when transporting the resident and while he/she is seated in the wheelchair. Interview with the Nursing Supervisor (RN #1) on 5/6/26 at 2:04 PM identified she was the supervisor on duty when the resident fell on 4/11/26 and noted the resident was seated on the floor in front of the wheelchair with no leg rests in place. Review of the Chair/Wheelchairs policy and procedure identified resident will be provided with appropriate seating to maintain comfort, body alignment and promote maximum level of functioning. The procedure identifies to transfer the resident to the wheelchair and adjust, assure extremities are supported. The procedure further identifies that the leg rests are used if the resident is unable to self-propel wheelchair. The facility failed to ensure routine maintenance inspections of the shower chairs were conducted and failed to implement a plan to inspect the shower chairs following the collapse of the wheelchair where Resident #57 sustained minor injuries.