STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075345	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #3) reviewed for abuse, the facility failed ensure the resident was free from verbal mistreatment. The findings include: Resident #3 was admitted with diagnoses that included attention and concentration deficit and asthma. A quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS of 11 indicating moderately impaired cognition and required assistance with ALDs. A resident care plan dated 9/10/2024 identified Resident #3 had ineffective coping with accusatory behaviors due to cognitive impairment. Interventions included assist of two (2) staff with care, explain all procedures, speak simply and to offer support and reassurance. A facility reportable event (RE) form dated 11/11/2024 at 7:04 PM identified on 11/10/2024 at 12 PM, Person #3 reported LPN #3 had made inappropriate comments to Resident #3. An RN assessment identified no injuries, LPN #3 was suspended pending investigation and social work provided emotional support. Review of the State Agency reportable event identified Resident #3 reported LPN #3 said the resident was here because he/she did cocaine and snorted so much it caused him/her crazy. LPN #3 denied the allegation, and what was allegedly said to the resident was he/she was at the facility because he/she was a crack head and all he/she did was snort up your nose. The facility RE report summary dated 11/20/2024 identified the facility was notified on 11/10/2024 that LPN #3 was alleged to make inappropriate remarks to Resident #3. The facility investigation concluded inappropriate remarks were made. (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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(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	Interview and review of her facility statement with NA #3 on 1/8/2025 at 11:58 AM identified on 11/10/2024 at 11:30 AM when observed Resident #3 in her/his wheelchair at the nurse's station and Resident #3 and LPN #3 were arguing loudly. NA #3 stated she heard LPN #3 say to Resident #3 that he/she was a crack head and all Resident #3 did was snort up his/her nose and that is why Resident #3 had to be at the facility. Resident #3 responded to LPN #3 with comments, and LPN #3 then stated to Resident #3 you should be in jail where you could s*** d***. NA #3 stated NA #4 and #5 also were nearby when the incident occured. NA #3 then moved Resident #3 into the hallway as Resident #3 made a comment to LPN #3. LPN #3 then came to Resident #3, pulled Resident #3's wheelchair back to the nurse's station, and while standing in front of Resident #3 with her finger in Resident #3's face, she asked Resident #3 if he/she was still going to jail. LPN #3 further stated that her ex was a drug dealer. NA #3 walked away, stated she was unsure what to do, and she did not report the incident to her supervisor immediately. She later saw a family member visit about 2 PM and Person #3 asked NA #3 if she knew what happened, and NA #3 told Person #3 what she had witnessed. NA #3 stated after Person #3 reported the incident, RN #2 (nursing supervisor) asked her to write a statement. Interview and review of written statement with NA #4 on 1/8/2025 at 10:45 AM identified he assisted NA #5 to complete AM care for Resident #3 on 11/10/2024 around 10:00 AM; LPN #3 was also in the room and provided redirection as Resident #3 was getting agitated. Resident #3 was calling staff derogatory names and yelling at them as they provided care. NA #4 stated Resident #3 routinely yells, calls out, can be physically aggressive and make derogatory statements towards staff during care. After the care was provided, Resident #3 appeared calmer and was transferred to the wheelchair. NA #4 stated about 11:30 AM, he was at the nurse's station charting when he heard LPN #3 and Resident #3 loudly arguing and that LPN #3 told Resident #3 that she/he was at the facility because Resident #3 had gotten high on coke. NA #4 stated he then left the area to answer a call light and he did not report the incident to the supervisor/RN #3. NA #4 stated he then walked away from the area to answer a call light, and he did not report the incident when it occurred at 11:30 AM. About 3 PM, RN #2 asked him if he had witnessed an inappropriate interaction between Resident #3 and LPN #3 and asked him to write a statement, and he wrote his statement. Interview and facility documentation review with RN #2/day shift supervisor on 1/8/2025 at 12:30 PM identified on 11/10/2024 Person #3 reported a back and forth that occurred between Resident #3 and LPN #3, and she could not recall the specific details. RN #2 stated she notified the DON, but she did not ask NA #3 and #4 for statements based on Person #3's concerns, and stated she should initiate a facility grievance. Interview with the DON on 1/8/2025 at 1:00 PM identified that on 11/10/2024 at 6:30 PM, the evening supervisor, RN #4, called her and told her Resident #3's family member requested she call the police about a reported earlier inappropriate interaction with Resident #3 and LPN #3. The DON asked RN #4 for the names of the day shift staff on the Resident #3's unit and their phone numbers, directed RN #4 to notify the police, directed to make sure LPN #3 was not working on 11/11/2024, and then began to contact all the identified staff. The facility investigation identified LPN #3 had made the derogatory statements to Resident #3 and LPN #3's employment was terminated. Although attempted, interviews with NA #5 and LPN #3 were not obtained during survey. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse, Resident dated 7/23/2023 directed in part, that abuse or mistreatment of any kind toward a resident was strictly prohibited. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation with resulting physical pain or mental anguish. Verbal abuse was defined as the use of oral, written or gestured language that included disparaging and derogatory terms to residents regardless of their disability or ability to comprehend. The facility Resident's [NAME] of Rights Policy directed in part that residents have the righty to be treated with consideration, respect and full recognition of their dignity and individuality. Facility documentation review identified staff education was initiated on 11/15/2024 regarding the facility abuse policy, code of conduct, customer service and de-escalation techniques. A QAPI meeting was held on 11/10/2024, and audits were initiated on 11/20/2024. Based on review of facility documentation, past non-compliance was identified.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #3) reviewed for abuse, the facility failed ensure staff reported an allegation of abuse timely, and the facility failed to notify the State Agency timely when it became aware of an allegation of abuse. The findings include: Resident #3 was admitted with diagnoses that included attention and concentration deficit and asthma. A quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS of 11 indicating moderately impaired cognition and required assistance with ALDs. A resident care plan dated 9/10/2024 identified Resident #3 had ineffective coping with accusatory behaviors due to cognitive impairment. Interventions included assist of two (2) staff with care, explain all procedures, speak simply and to offer support and reassurance. A facility reportable event (RE) form dated 11/11/2024 at 7:04 PM identified on 11/10/2024 at 12 PM, Person #3 reported LPN #3 had made inappropriate comments to Resident #3. A RN assessment identified no injuries, LPN #3 was suspended pending investigation and social work provided emotional support. The report further indicated the facility first knew about the incident on 11/10/2024 at 6:30 PM (24 hours and 34 minutes prior to the report). Review of the State Agency reportable event identified Resident #3 reported LPN #3 said the resident was here because he/she did cocaine and snorted so much it caused him/her to be crazy. LPN #3 denied the allegation, and what was allegedly said to the resident was he/she was at the facility because he/she was a crack head and all he/she did was snort up your nose. Interview and review of her facility statement with NA #3 on 1/8/2025 at 11:58 AM identified on 11/10/2024 at 11:30 AM when observed Resident #3 in her/his wheelchair at the nurse's station and Resident #3 and LPN #3 were arguing loudly. NA #3 stated she heard LPN #3 say to Resident #3 that he/she was a crack head and all Resident #3 did was snort up his/her nose and that is why Resident #3 had to be at the facility. Resident #3 responded to LPN #3 with comments, and LPN #3 then stated to Resident #3 you should be in jail where you could s*** d*** and Resident #3 became quiet. NA #3 stated NA #4 and #5 also were nearby. NA #3 then moved Resident #3 into the hallway as Resident #3 made a comment to LPN #3. LPN #3 then came to Resident #3, pulled Resident #3's wheelchair back to the nurse's station, and while standing in front of Resident #3 with her finger in Resident #3's face she asked Resident #3 if he/she was still going to jail. LPN #3 further stated that her ex was a drug dealer. NA #3 walked away and stated she was unsure what to do, and she did not report the incident to her supervisor immediately. She later saw a family member visit about 2 PM (2 hours and 30 minutes after the witnessed incident) and Person #3 asked NA #3 if she knew what happened, and NA #3 told Person #3 what she had witnessed. NA #3 stated after Person #3 reported the incident, RN #2 (nursing supervisor) asked her to write a statement. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of written statement with NA #4 on 1/8/2025 at 10:45 AM identified he assisted NA #5 to complete am care for Resident #3 on 11/10/2024 at around 10:00 AM, LPN #3 was also in the room and provided redirection as Resident #3 was getting agitated. Resident #3 was calling them derogatory names and yelling at them as they provided care. NA #4 stated Resident #3 routinely yells, calls out, can be physically aggressive and make derogatory statements towards staff during care. After the care was provided, Resident #3 appeared calmer and was transferred to the wheelchair. NA #4 stated about 11:30 AM, he was at the nurse's station charting when he heard LPN #3 and Resident #3 loudly arguing and that LPN #3 told Resident #3 that she/he was at the facility because Resident #3 had gotten high on coke. NA #4 stated he then left the area to answer a call light, and he did not report the incident to the supervisor/RN #3. NA #4 stated he then walked away from the area to answer a call light, and he did not report the incident when it occurred at 11:30 AM. About 3 PM (3 hours and 30 minutes after the witnessed incident), RN #2 asked him if he had witnessed an inappropriate interaction between Resident #3 and LPN #3 and asked him to write a statement, and he wrote his statement. Interview and facility documentation review with RN #2/day shift supervisor on 1/8/2025 at 12:30 PM identified on 11/10/2024 Person #3 reported a back and forth that occurred between Resident #3 and LPN #3, and she could not recall the specific details. RN #2 stated she notified the DON, but she did not ask NA #3 and #4 for statements based on Person #3's concerns, and stated she should initiate a facility grievance. Interview and facility documentation review with RN #4/evening shift supervisor on 1/8/2025 at 1:10 PM identified on 11/10/2024 Person #3 reported a back and forth that occurred between Resident #3 and LPN #3, and she could not recall the specific details, and she asked NA #3 and NA #4 to write statements. RN #4 further stated that she notified the DON of the allegation. Interview with the DON on 1/8/2025 at 1:00 PM identified that on 11/10/2024 at 6:30 PM, the evening supervisor, RN #4, called her and told her Resident #3's family member requested she call the police about a reported earlier inappropriate interaction with Resident #3 and LPN #3. RN #4 indicated RN #3 had initiated a grievance during the day shift. The DON stated NA #3 and NA #4 should have immediately reported the incident to the supervisor when it occurred, and she was unable to explain why they did not report it immediately when it occurred at 11:30 AM. The DON further stated, RN #3 should have notified her at the time of the family's concern so she could have directed RN #3 what actions to take at that time. Review of the State Agency online reportable event submitted by the facility for this incident identified a time/date stamp of 11/11/2024 at 7:04 PM. The DON stated that although she had identified an allegation of abuse the morning of 11/11/2024 before lunch, and allegations of abuse are required to be submitted within two (2) hours, the DON stated she had to review the information with the facility's corporate services before she could submit the information to the State Agency. Although attempted, interviews with NA #5 and LPN #3 were not obtained during survey. (continued on next page)

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Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse, Resident dated 7/23/2023 directed in part, abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation with resulting physical pain or mental anguish. Verbal abuse is defined as the use of oral, written or gestured language that included disparaging and derogatory terms to residents regardless of their disability or ability to comprehend. Anyone witnessing and/or having knowledge of abuse or mistreatment of any kind towards a resident will report the incident immediately to the supervisor, DON and Administrator. The Administrator or DON or designee will immediately conduct an investigation upon submission of a report to the state health authority within 2 hours of notification of the alleged abuse. Facility documentation review identified staff education was initiated on 11/15/2024 regarding the facility abuse policy, code of conduct, customer service and de-escalation techniques. A QAPI meeting was held on 11/10/2024, and audits were initiated on 11/20/2024. Based on review of facility documentation, past non-compliance was identified.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for wounds, the facility failed to ensure the resident care plan was revised timely to include resident refusals of wound care. The findings include: Resident #2's diagnoses included a non-pressure chronic left foot ulcer and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being cognitively intact, and had two (2) unstageable diabetic ulcers, had pressure reducing devices, and received nutrition and ointments/medication for pressure ulcer/injury care. The Resident Care Plan (RCP) dated 9/19/2024 identified Resident #2 was at risk for skin breakdown due to decreased mobility, incontinence, poor nutrition, poor circulation, pronounced body prominences, and altered sensation. Interventions directed use of a pressure reducing mattress and cushion on wheelchair, consult with wound specialist as ordered/needed, apply barrier cream with incontinent care, and observe for signs of skin breakdown. Review of the physician orders identified the following: 1. Physician orders dated 8/20/2024 directed for Resident #2, to cleanse left Achilles wound with normal saline, apply skin prep to peri wound, followed by Dakins Solution ¼ strength-soaked gauze, and cover with dry sterile dressing, twice a day, and as needed. 2. Physician orders dated 9/12/2024 directed to provide Resident #2 with Juven beverage, twice a day. 3. Physician orders dated 9/12/2024 directed for Resident #2 to use foam boots to offload heels at all times when in bed and in chair. 4. Physician orders dated 10/4/2024 directed for Resident #2, to cleanse wound with warm soap and water and then pat dry, peri wound care: apply triad (zinc ointment) to peri wound, apply primary dressing, apply Santyl ointment 2mm thick layer to wound only (nickel thick) and place a secondary dressing (hydrofera) blue and apply abdominal pad cover with roll gauze, change dressing daily and as needed. Review of the Treatment Administration Record (TAR) for September, October, November, December 2024 identified the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	• Resident #2 refused wound dressing change on 9/4 and 10/7/2024. • Resident #2 refused Juven (therapeutic beverage for wound healing) on 10/17, 10/27, 10/28, 10/31, 11/10, 11/24, and 12/4/2024. Clinical record review identified the following: • Review of nursing notes for the month of October 2023 identified Resident #2 refused to wear his/her multipodus boots on 10/3/2024. Review of the RCP failed to identify a care plan for refusals of care and medications or wound care treatments. Interview with the DON on 1/2/2024 at 1:00 PM identified if a resident exhibitis behaviors of repetitive refusals, the resident should be care planned for refusing care with interventions to include addressing the refusals. The DON identified she was unaware that Resident #2 refused medications and wound dressing changes and indicated Resident #2's care plan should include refusals of care. Review of the Care Plan Policy dated 10/30/2020 directed in part, a comprehensive and individualized plan of care will be developed for each resident. The care plan will guide caregivers to assist residents to achieve or maintain their highest practical level of well-being.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for wounds, the facility failed to act timely on a wound consultant order, and failed to ensure a low air-loss mattress was maintained in place in accordance with wound consultant orders. The findings include: Resident #2's diagnoses included a non-pressure chronic left foot ulcer and diabetes mellitus. Review of the Wound Center Physician Notes and Orders dated 9/11/2024 identified Resident #2 had a left lower extremity unstageable ulceration and a left lower extremity ankle/Achilles stage four (4) ulceration. The wound center orders directed Resident #2 required pressure relief devices to include waffle booties, pressure relief cushion on wheelchair (ROHO), and a low air-loss mattress. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of eight out of fifteen (08/15), indicative of mildly impaired cognition and had two (2) unstageable diabetic ulcers, had pressure reducing devices, and received nutrition and ointments/medications for pressure ulcer/injury care. The Resident Care Plan (RCP) dated 9/19/2024 identified Resident #2 was at risk for skin breakdown due to decreased mobility, incontinence, poor nutrition, poor circulation, pronounced body prominences, and altered sensation. Interventions directed use of a pressure reducing mattress and cushion on wheelchair, consult with wound specialist as ordered/needed, apply barrier cream with incontinent care, and observe for signs of skin breakdown. Record review identified although the wound consultant order dated 9/11/2024 directed use of a low air-loss mattress, the order was not obtained from the attending (in-house physician) for use of the specialized mattress. Interview with RN #3 and DON on 1/2/2025 at 12:15 PM identified Resident #2 was seen weekly at a wound clinic for his/her left lower extremity wounds and Resident #2 had multiple pressure relieving interventions, including a low air-loss mattress. RN #3 described a low air-loss mattress at this facility would have a mechanical device at the end of the bed that would require staff to enter settings based on the resident's weight. RN #3 stated there were no other types of the low air-loss mattresses use in the facility. Intermittent observations on 1/2/2025 during the 7:00 AM to 3:00 PM shift identified Resident #1 was on a regular bed mattress, without the benefit of being on a low air-loss mattress as per physician orders. Interview and observation of Resident #2's bed with RN #3 and DON on 1/2/2025 at 12:30 PM confirmed the mattress on Resident #2's bed was a standard mattress, and Resident #2 did not have the low air-loss mattress in place as ordered. Subsequent to surveyor inquiry, RN #3 and the DON identified a low air-loss mattress would be placed on the bed on 1/2/2025. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 1/2/2025 at 1:30 PM identified she was responsible for ensuring wound care treatments/plans are followed for the residents. RN #3 stated she could not identify the date she performed her last wound audit, but stated Resident #2 had a low air-loss mattress in place on the date she performed the audit. RN #3 stated after observation with surveyor at 12:30 PM, she identified on an unknown dated Resident #2's low air-loss mattress device had broken and staff had exchanged the mattress with a regular mattress, due to not having another low air-loss mattress device in stock. RN #3 stated the facility had additional low air-loss mattresses in supply and the correct mattress would be applied to the bed. Review of the undated facility Wound and Skin Care Policy directed in part, the facility will provide quality resident care and outcomes by maintaining skin integrity and promoting wound healing utilizing a skin/wound care protocol. Although requested, a facility policy regarding following physician orders was not provided.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 clinical record review, facility documentation review, facility policy review, and interviews for one of eight residents (Resident #1) reviewed for accidents, the facility failed to ensure staff supervision was conducted timely to identify a missing resident's whereabouts, failed to act timely when a resident was identified to be missing, and failed to follow their own policy and continue to search for a missing resident whose whereabouts were unknown for approximately six hours. The facility was later notified the resident was found waist deep in an icy pond. The failures resulted in a finding of Immediate Jeopardy. The finding includes: Resident #1's diagnoses included metabolic encephalopathy, dementia, depression, and anxiety disorder, and a history of alcohol abuse. The Resident Care Plan (RCP) dated 11/18/2024 identified Resident #1 had impaired memory, impaired recall and impaired decision-making skills related to dementia. Interventions directed to orient to room/staff, offer support and reassurance, and gentle reminders when resident is confused or forgetful. Record review identified Resident #1 was responsible for him/herself (had no Power of Attorney or court appointed Conservator). Review of the Capacity to Meet Minimal Basic Needs assessment dated [DATE] identified Resident #1 did not have the capacity to meet his/her minimal basic needs in the community. Resident #1 was identified to have a history or other known behaviors that could place him/her at risk of seeking unescorted exit from a supervised setting related to recent history of substance use/relapse risk. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen (10/15), indicative of moderately impaired cognition and was independent with ADL's (activities of daily living) and mobility. Physician orders dated 11/28/2024 directed Resident #1 was approved for LOA (leave of absence) with a responsible party. Elopement risk assessment dated [DATE] identified Resident #1 was not at risk for elopement from the facility. Facility reportable event report dated 12/28/2024 at 5:14 PM identified on 12/27/2024 at 8:15 PM the facility became aware (event first known by the facility at 8:15 PM) that Resident #1 left the facility premises under an LOA order requiring accompaniment by a responsible party. The resident accessed a vehicle on the premises and drove off unaccompanied. He/she was later involved in a motor vehicle accident. Resident #1 was evaluated at a local clinic and discharged with no injuries. Law enforcement was involved, and the resident was discharged from the clinic. Review of local weather reports identified the temperature range on 12/27/2024 between 3 and 8 PM was 30 to 38 degrees Fahrenheit (F). (continued on next page)

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	075345	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Coccomo	33 Cone Ave Meriden, CT 06450

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Emergency medical services (EMS) report dated 12/27/2024 at 7:01 PM identified per fire fighters that rescued patient, the patient did not follow their directions, got out of the car, fell through the ice, and was waist deep in the water for approximately five (5) minutes before able to be extricated. Body temperature recorded was 97.5 F. Patient had been dried off and is warm to touch. Patient stated was visiting a parent, then stated was visiting a friend, then stated came for medical care. Initially denied alcohol use, then stated had one (1) glass of wine, then stated given several glasses of coconut vodka by a nurse, and stated has been going through a rough time and drinking heavily. Adamant about not knowing the event. EMS fire department report dated 12/27/2024 at 7:03 PM identified EMS responded to a vehicle in the water, with one (1) occupant. Upon arrival, rescue crews had removed the patient from the water, removed wet clothing, applied hot packs under the patient's arms and applied warming blankets, body temperature 97.3 F. First responders reported the patient struck several mailboxes, a rock and then ended up in the pond. Resident #1 initially appeared somnolent, reluctant to follow directions or answer questions, reported some neck tenderness, was alert to name and date of birth only, and was unaware of the event. Resident #1 admitted to consuming three (3) vodka drinks. The incident summary dated 12/31/2024 identified Resident #1 was alert and oriented (BIMS of 15 out of 15). The summary indicated on 12/27/2024 Resident #1 departed the facility premises alone, despite having an LOA order requiring accompaniment by a responsible party. Resident #1 accessed a vehicle on the premises, which the facility later determined belonged to the resident. While off premises, the resident was involved in a motor vehicle accident, was found to have no injuries but had an alcohol level of 268. The clinic discharged the resident to a local shelter on the morning of 12/28/2024. The summary further indicated Resident #1 called the facility on 12/30/2024, requested return, and staff transported Resident #1 back to the facility and was re-admitted . Interview and review of facility security video footage with the Administrator and DON on 1/6/2024 at 1:05 PM identified the video time stamped 12/23/2024 at 6:34 PM showed Resident #1 driving into the parking lot and parking. Interview identified the facility had reviewed additional video footage dated 12/27/2024 at 1:53 PM that identified Resident #1 left the nursing unit, went to Receptionist #1, and then exited the facility through the main lobby doors at 2:04 PM. Resident #1 was then seen at 2:06 PM driving off the facility grounds and had no coat or personal belongings with him/her. Record review identified staff were unaware of Resident #1's whereabouts between 2:04 PM to 8:15 PM (6 hours and 11 minutes), when they received a call from the police informing them that Resident #1 was involved in a motor vehicle accident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Receptionist #1 on 1/6/2025 at 12:30 PM identified on 12/26/2024 when Resident #1 requested to obtain items from his/her car, Receptionist #1 called the DON for direction regarding allowing the resident to go outside alone to obtain items from her car. Receptionist #1 stated the DON indicated Resident #1 was allowed to go to his/her car alone. Interview identified Resident #1 made two (2) or three (3) trips to his/her car and brought multiple bags back into the facility. Receptionist #1 stated she did not know Resident #1 had a car prior to 12/26/2024, and she also notified LPN #4/charge nurse who said she did not know the resident had a car. On 12/27/2024 when Resident #1 requested to obtain items from his/her car, she allowed the resident to go to his/her car alone because the DON had directed on 12/26/2024 that the resident could go to his/her car alone. Receptionist #1 stated Resident #1 was wearing shoes, pants, and a shirt, and was not dressed to indicate he/she was leaving the facility - had no coat or purse. Resident #1 went to his/her vehicle, and Receptionist #1 stated she did not see Resident #1 return into the facility, and she did not ensure the resident returned back into the facility. Her shift ended at 3:15 PM, and she did not notify anyone that Resident #1 had gone outside to his/her car. Receptionist #1 confirmed she did not follow-up to look outside to see if Resident #1's vehicle was gone or where Resident #1 was, because she did not know the make, model, and color of the car. Interview with SW #1 on 1/7/2025 at 9:00 AM identified on 12/27/2024, at 5:30 PM (3 hours and 26 minutes after the resident went to his/her car), SW #1 went to see Resident #1 to discuss discharge planning and identified Resident #1 was not in his/her room. SW #1 began to search for Resident #1 throughout the building in all the common areas, checked the visitor log, and other resident rooms (friends) and was unable to locate Resident #1. SW #1 notified the DON (was in the facility), RN #2/supervisor, LPN #2/charge nurse, and any NAs she saw that she was looking for Resident #1. SW #1 instructed LPN #2 and the nurse aides (NAs) to help with the search but was unable to confirm if they searched; Receptionist #1 stated when she told the NAs she could not locate Resident #1, they responded that Resident #1 was probably playing cards somewhere. Afterwards, SW #1 met with the DON and Administrator with an update, and the DON directed SW #1 to call Resident #1's cell phone; Resident #1 did not answer the phone, and SW #1 continued to search the facility. SW #1 confirmed she only searched the inside of the facility, looked through multiple windows to view the outside of the facility, but did not search outside of the facility. SW #1 indicated she continued to search the facility and resumed her normal duties until leaving the facility at approximately 8:30 PM, without locating Resident #1. SW #1 identified she did not call any codes overhead in accordance with facility policy (i.e. Dr. Hunt), did not call the police, and did not search the outside premises while leaving the facility. Interview with RN #2 on 01/07/2025 at 9:10 AM identified on 12/27/2024 she was the supervisor when SW #1 notified her that she was looking for Resident #1 to discuss discharge planning. RN #2 indicated she searched inside the facility but was unable to locate the resident. RN #2 called Resident #1's cell phone, but there was no answer. RN #2 identified she did not call a code overhead for a missing resident to alert all staff (i.e. Dr. Hunt), and she did not call the local police or search the outside of the facility. RN #2 indicated that since Resident #1 was alert and oriented, was not conserved and was self-responsible, and thought the resident had independent LOA privileges, that she believed Resident #1 must have left the building and forgot to sign out in the LOA book. RN #2 identified that at approximately 8:15 PM, a Police Officer from another town (26 miles away) identified Resident #1 was intoxicated and drove his/her vehicle into an icy pond and was being taken to the local area hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Regional RN #2 on 1/6/2025 at 6:33 PM identified Resident #1 did not elope from the facility, and stated Resident #1 had an unauthorized absence from the facility. Regional RN #2 stated although Resident #1 was alert with a BIMS of 15 (on 12/30/2024), staff should have done rounds at the beginning and end of their shifts, and every two (2) hours to ensure all residents whereabouts, and Resident #1 should have been identified as missing prior to 5:30 PM. Interview with Regional RN #1 and Regional RN #2 with the Administrator and DON present on 1/7/2025 at 12:30 PM identified a missing resident was defined as the staff's inability to find a resident, but a resident's cognitive status affects the immediacy. The facility process for a missing resident included following the facility policy: searching the facility inside and the outside grounds, checking the LOA sign-out book, calling the resident's contacts, and to follow the facility policy regarding a missing resident. Regional RN #1 indicated an unauthorized leave was defined as a resident who is alert and oriented, capable of meeting their needs on the outside, leaving the building without signing out. The facility process when a resident has unauthorized leave was to call the resident's phone and contacts listed, review the sign-out book, interview staff and residents regarding whereabouts, call the shelters/hospital/police, and call the physician. Although Regional RN #1 defined differences with missing residents versus unauthorized leaves, Regional RN #1 identified that all missing residents should be treated the same - if it was a missing resident or unauthorized leave. Regional RN #1 identified for Resident #1's event on 12/27/2024, she was not able to confirm that staff called a code overhead (i.e. Dr. Hunt), called the police, or performed a search of the outside of the premises as per facility policy. Interview with DON on 1/7/2025 at 3:35 PM identified she was notified on 12/26/2024 that Resident #1 had the keys to his/her vehicle located on the premises, but did not question further or implement any interventions due to Resident #1 being alert and orient, no history/behaviors of elopement, and was scheduled to be discharged in the next week. The DON stated she was in the building on 12/27/2024 when SW #1 notified her that she could not locate Resident #1. The DON went to RN #2 to see if she had any additional information on the resident's whereabouts, continued to search inside the facility and instructed RN #2 and SW #1 to contact Resident #1's cell phone and listed contacts; the family was unable to be reached. DON indicated she told to SW #1 and RN #2 to notify the police if unable to find Resident #1 but was unable to verify if she gave them a specific timeframe of when to call. The DON stated her expectation was that the staff would call within one (1) to two (2) hours of not getting in touch with Resident #1 or locating him/her. The DON stated she left the building and went home at around 6 or 6:30 PM without locating Resident #1, and without paging overhead to alert all staff the resident was missing, without searching the outside grounds and without notifying the local police. The DON further stated she received a call from RN #2 at approximately 8 or 8:30 PM that Resident #1 was found by the police. Email interview with the local Police Department Records Clerk (PRC) #1 on 1/8/2025 at 9:19 AM identified the local police department had no records in their system that they were notified Resident #1 was unable to be located by facility staff on 12/27/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Missing Resident Policy dated 8/2023 identified the facility will provide rapid interventions when it is determined that a resident's whereabouts are unknown. The procedure identified the facility will: notify the Nursing Supervisor immediately, the supervisor will alert facility staff by overhead paging, attention all staff, Dr. Hunt is looking for (resident's name) and repeat the page. A room-to-room check will be instituted immediately on all units and all personnel in the building will join in the search for the missing resident. If the resident is not located after the internal search, assigned personnel will institute a search of the outside grounds and surrounding areas. The supervisor will notify the DON and Administrator. The police will be notified (911) and provide a full description, a photograph of the resident and any pertinent medical issues. Although requested, the facility did not provide a policy for unauthorized resident absence.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to perform an elopement risk assessment after a resident returned to the facility after an identified unauthorized absence and the facility failed to accurately complete an elopement risk assessment after an unauthorized resident absence. The findings include: Resident #1's diagnoses included metabolic encephalopathy, dementia, depression, and anxiety disorder, and a history of alcohol abuse. The Resident Care Plan (RCP) dated 11/18/2024 identified Resident #1 had impaired memory, impaired recall and impaired decision-making skills related to dementia. Interventions directed to orient to room/staff, offer support and reassurance, and gentle reminders when resident is confused or forgetful. Record review identified Resident #1 was responsible for him/herself (had no Power of Attorney or court appointed Conservator). Review of the Capacity to Meet Minimal Basic Needs assessment dated [DATE] identified Resident #1 did not have the capacity to meet his/her minimal basic needs in the community. Resident #1 was identified to have a history or other known behaviors that could place him/her at risk of seeking unescorted exit from a supervised setting related to recent history of substance use/relapse risk. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen (10/15), indicative of moderately impaired cognition and was independent with ADL's (activities of daily living) and mobility. Physician orders dated 11/28/2024 directed Resident #1 was approved for LOA (leave of absence) with a responsible party. Elopement risk assessment dated [DATE] identified Resident #1 was not at risk for elopement from the facility. Facility reportable event report dated 12/28/2024 at 5:14 PM identified on 12/27/2024 at 8:15 PM the facility became aware (event first known by the facility at 8:15 PM) that Resident #1 left the facility premises under an LOA order requiring accompaniment by a responsible party. The resident accessed a vehicle on the premises and drove off unaccompanied. He/she was later involved in a motor vehicle accident. Resident #1 was evaluated at a local clinic and discharged with no injuries. Law enforcement was involved, and the resident was discharged from the clinic. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident summary dated 12/31/2024 identified Resident #1 was alert and oriented (BIMS of 15 out of 15). The summary indicated on 12/27/2024 Resident #1 departed the facility premises alone, despite having an LOA order requiring accompaniment by a responsible party. Resident #1 accessed a vehicle on the premises, which the facility later determined belonged to the resident. While off premises, the resident was involved in a motor vehicle accident, was found to have no injuries but had an alcohol level of 268. The clinic discharged the resident to a local shelter on the morning of 12/28/2024. The summary further indicated Resident #1 called the facility on 12/30/2024, requested return, and staff transported Resident #1 back to the facility and was re-admitted . Record review identified Resident #1 was out of the facility on 12/27/2024 from 2:04 PM without staff knowledge. Staff initiated an interior building search at 5:30 PM and did not locate the resident prior to the DON and SW leaving the facility for the day, staff did not have knowledge of Resident #1's whereabouts until they were notified by the police at 8:15 PM (6 hours and 11 minutes after the resident left the facility without staff knowledge). Review failed to identify an elopement risk assessment was completed after Resident #1 was readmitted to the facility on [DATE]. Subsequent to surveyor inquiry, the facility performed an elopement risk assessment dated [DATE] at 4:47 PM. a. Review of the elopement risk assessment dated [DATE] at 4:47 PM completed by RN #2, identified Question #2 asked does the resident have any history of elopement? RN #2 documented an answer of no. Interview with the DON on 1/7/2025 at 3:35 PM identified the facility did not perform an elopement risk assessment upon readmission to the facility on [DATE] (after the unauthorized absence on 12/27/2024) due to Resident #1's hospitalization was less than 24 hours. The DON stated the facility team reviewed the unauthorized absence incident and determined that when any resident is sent to the hospital for evaluation, but returns within 24 hours, the facility does not consider this a re-admission, but just as a continuation of care. The DON stated although Resident #1 was not in the facility from 12/27/2024 to 12/30/2024, Resident #1's hospitalization was brief (12/27 to 12/28/2024 and the hospital discharged Resident #1 to the community) and did not exceed the 24-hour hospitalization timeframe that would require new assessments to be completed. The DON further stated she believed RN #2's elopement risk assessment dated [DATE] was completed correctly and documented correctly because Resident #1 did not elope from the facility but had an unauthorized leave of absence. The DON concluded that Resident #1 had no prior history of elopements, was alert and oriented, was responsible for him/herself, and was not conserved and indicated that an elopement assessment was not required. Review of the Elopement Risk Policy without a date documented identified all residents are evaluated for risk of elopement on admission and readmission.