

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/16/2025
NAME OF PROVIDER OR SUPPLIER  Apple Rehab Cocomo		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, facility documentation, facility policy, and interviews, the facility failed to ensure and maintain a clean, comfortable, and homelike environment. The findings include:</p> <p>Observations during tour of the facility on 6/10/25 and 6/11/25 identified on units 100, 200, and 300 the floors were soiled, paint was peeling off walls, sinks and faucets were leaking or would not turn on or off, sinks were stained orange and red, closet doors in resident rooms were off the hinges and stained, shower room floor tiles broken or pieces missing, shower rooms had a dark substance covering the edges of the floors, and bathroom lights that needed to be replaced.</p> <p>Observations on unit 100 identified room [ROOM NUMBER] had paint peeling off the walls, the nurses' station floors were soiled with debris, and room [ROOM NUMBER] had a faucet that continuously dripped.</p> <p>Observations on unit 200, rooms [ROOM NUMBERS] had a continuously dripping faucet and the faucet handles did not work. rooms [ROOM NUMBERS] had sinks that were stained orange and red, with continuous running water that would not shut off, and closet doors were off their hinges.</p> <p>Observations on unit 300 identified the residents' shower room had broken and missing floor tiles, the edges of the shower room floor were soiled with a dark substance, room [ROOM NUMBER] had lights out in the bathroom, and hallway floors were soiled with a sticky substance.</p> <p>Interview with Resident #4, who resided on unit 100, on 6/10/25 at 9:00 AM identified that the walls needed to be painted, floors needed to be cleaned, sinks and faucets were old and needed to be replaced. Resident #4 stated some projects had been started but had not been completed.</p> <p>Interview with Resident #5, who resided on unit 300, on 6/10/25 at 10:07 AM identified he/she was very unhappy with the appearance of the facility, that repairs were not being done, and he/she felt the administration was not interested in repairing the building. Resident #5 stated although he/she had spoken to the Administrator who assured repairs were ongoing, no actual repairs could be seen, such as walls that needed to be painted, furniture, sinks, and faucets that needed to be replaced.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Interview with Resident #6, who resided on unit 200, on 6/10/25 at 10:30 AM stated he/she had been a resident there for over a year and that the building needed repair. Resident #6 stated he/she felt the facility needed to be updated, and the maintenance staff were not making any repairs to the building. Resident #6 stated he/she had spoken to the Administrator and assured repairs were being made, but shower tiles were broken, sinks leaked, and painting of some areas had been started but not completed.</p> <p>Interview with the Director of Maintenance on 6/10/25 at 11:00 AM stated he had taken the role of Director of Maintenance four (4) months ago and had not been trained by the former Director of Maintenance. The Director of Maintenance stated he was not aware of any projects the former director had started, and he was unable to locate any maintenance logs for repairs or invoices for equipment. The Director of Maintenance stated he was assembling a maintenance logbook for ongoing projects, new projects, and completed projects.</p> <p>Interview with the Director of Housekeeping/Laundry on 6/10/25 at 11:40 AM stated it is her responsibility to ensure the facility was kept clean, and she frequently works in the laundry, and sends a laundry aide to do housekeeping. The Director of Housekeeping/Laundry stated the facility was actively recruiting for housekeeping positions, but that it has been a challenge. The Director stated a cleaning schedule was provided to each housekeeper.</p> <p>Interview with the Interim Administrator on 6/10/25 at 12:30 PM identified it was ultimately the responsibility of the Administrator to ensure the facility maintains a clean, comfortable, homelike, and safe environment, and that the Director of Maintenance was supposed to report to the Administrator any and all repairs that were needed. The Interim Administrator stated the former Director of Maintenance had been terminated and the newly appointed Director of Maintenance and the Corporate Project Manager were in the process of assessing what needed to be repaired immediately, obtaining quotes and invoices to proceed with repairs.</p> <p>Interview with the Corporate Project Manager on 6/10/25 at 1:00 PM identified that the former Director of Maintenance had been terminated, and he was now working with the New Director to make the necessary repairs to the building.</p> <p>Observations made on 6/16/25 on unit 300 identified the floors were soiled and sticky and faucets leaking or would not turn on or off.</p> <p>Interview with a charge nurse on 6/16/25 at 9:00 AM identified that she was sticking to the hallway floor on unit 300, the hall and resident rooms had not been swept, floors washed and she was unable to identify the last time housekeeping cleaned unit 300.</p> <p>Interview and observations on 6/16/25 at 9:09 AM with the Housekeeping Supervisor and Assistant Director of Maintenance. The Housekeeping Supervisor identified the floors were cleaned on Monday, Tuesday, Wednesday evenings and every Saturday and Sunday, and were last done yesterday, Sunday, however the floor did seem sticky and looked like it had been longer than a day since the floors were last cleaned.</p> <p>On 6/16/25 at 9:25 AM interview, observations, and review of facility documentation with the Assistant Director of Maintenance and Project Manager identified that they were aware of repairs were needed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Although requested, a facility policy for building maintenance was not provided.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation, facility policy, and interviews for one of three residents (Resident #7) reviewed for accidents, the facility failed to ensure the Resident Care Plan (RCP) was revised upon readmission to the facility, to direct the updated transfer status, after the resident sustained a facility acquired fracture due to a fall. The findings include:</p> <p>Resident #7's diagnoses included chronic obstructive pulmonary disease, depression and benign paroxysmal vertigo (crystals in ear that disrupt normal fluid flow causing false sense of motion and brief episodes of dizziness).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of ten), was dependent for shower transfers, required set up/clean up assistance with bed mobility and lower body dressing, was independent with bathing, upper body dressing, personal hygiene, transfers, ambulation of ten feet or less and was dependent with ambulation of 50 feet or greater distance.</p> <p>The RCP dated 4/24/2025, identified Resident #7 was at risk for falls, interventions directed to call if feeling dizzy and wait for assistance, call bell within reach when in bed or beside chair, encourage resident to wait for staff transfers and/or toileting, and transfer per MD orders.</p> <p>A nurses note dated 6/6/2025 at 10:40 AM by the RN supervisor, identified Resident #7 fell at approximately 10:20 AM, was assessed and complained of right knee pain and reported when he/she was attempting to sit down, he/she missed the wheelchair. The APRN was notified and ordered a onetime dose of Tramadol 100 mg (milligrams) and an x-ray of the right knee.</p> <p>The fall risk RCP was revised on 6/6/2025 to include interventions to in-service employees to utilize a gait belt when transferring/ambulating the resident and to have the resident feel for wheelchair arms before sitting down.</p> <p>A nurses note dated 6/6/2025 at 2:02 PM identified the x-ray revealed a right femur fracture, the family was notified, and Resident #7 was transferred to hospital.</p> <p>Review of hospital documents identified Resident #7 had a fall with right femur fracture and underwent ORIF (open reduction internal fixation) surgery on 6/7/2025. On 6/9/2025, physical therapy recommended Resident #7 return to the facility, for Resident #7 to pivot from the bed to the recliner only with assistance of two (2) staff and a rolling walker, and Resident #7 needed constant cues to maintain non-weight bearing status (NWB) on right lower extremity (RLE).</p> <p>A Physician's order dated 6/10/2025 directed transfer assist of two (2) total mechanical lift, non-ambulatory.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physical therapy note dated 6/12/2025 identified Resident #7 required a slide board transfer from bed to wheelchair with rehab only and max of assist of one (1). Resident #7 participated in sit to stand transfer training from wheelchair to bar with max assist of two (2), assisted to maintain NWB to the RLE, and education was provided to the nursing staff to use a total mechanical lift for transfers.</p> <p>Review of the Resident Care Card (RCC) directed independent with rolling walker, mobility assist of one (1) with gait belt for ambulation and transfer.</p> <p>Interview on 6/16/2025 at 10:33 AM with PT #1 identified that prior to the hospital admission, Resident #7 was a standby assist for transfers, sometimes had dizzy spells, and made staff aware dizziness. PT #1 further indicated facility policy directed gait belt use at the discretion of the staff member.</p> <p>Interview on 6/16/2025 at 11:00 AM with NA #1 identified she was assigned to provide care for Resident #7, she had not cared for Resident #7 since the day of the fall, and she did not know Resident #7's current transfer status. She indicated the RCC did not seem accurate, and she was waiting to clarify transfer status before transferring Resident #7 out of bed.</p> <p>Interview on 6/16/2025 at 11:12 AM with PTA #1 identified she worked with Resident #7 and chose to use a gait belt for safety. She indicated Resident #7's transfer status prior to the fall was supervision with a rolling walker. PTA #1 identified she updated Resident #7's transfer status, after the hospital admission, to an assist of two (2) using a sliding board with therapy and an assist of two (2) using a mechanical lift with nursing. She identified transfer status is communicated to nursing staff.</p> <p>Interview on 6/16/2025 at 1:48 PM with the DNS identified Resident #7 was care planned as a fall risk since admission to the facility. The DNS identified that on 6/6/2025, an aide was supervising Resident #7 while he/she ambulated with a rolling walker and then fell. Resident #7 attempted to sit in his/her wheelchair and missed the seat of the wheelchair then fell and sustained a fracture. The DNS identified that the RCC should have been updated upon readmission to the facility to reflect NWB to RLE and mechanical lift transfer with assistance of two (2) staff.</p> <p>Subsequent to surveyor inquiry on 6/16/2025, the RCC was updated to reflect a transfer assist of two (2) with mechanical lift.</p> <p>Review of facility Care Planning Policy directed in part, a comprehensive and individualized plan of care will be developed for each resident. The care plan is reviewed and updated at least quarterly and as necessary to reflect changes in the resident's status, resident Care Cards will be updated as needed to reflect changes made to the resident's plan of care.</p>		