STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075380	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Cromwell	156 Berlin Road Cromwell, CT 06416

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for wounds, the facility failed to ensure the State Agency was notified timely after the facility was notified of a threat of harm to a resident. The findings include: Resident #1 was admitted with diagnoses that included diabetes, autism, and acquired absence of right toes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3), indicative of severe cognitive impairment, and was independent for transfers and mobility. A resident care plan (RCP) dated 1/28/2026 identified a risk for skin issues due to picking and scratching and can be verbally and/or physically aggressive. Interventions directed family members (Person #1) liked to keep door closed (when visiting) to decrease distractions and noise. Record review identified Person #1, Person #2 and Person #4 were co-conservators for Resident #1. A nursing note dated 4/10/2026 at 2:12 PM, written by the DON, identified Person #1 was no longer allowed in the building. A body audit was done without any changes noted to the skin. Resident #1 appeared relaxed and following simple commands. The door to the room was open at this time. Medical Director also saw Resident #1 on 4/10/2026. Staff were notified Person #1 was not allowed on the premises. A physician progress note, written by the Medical Director dated 5/8/2026 (29 days after the email was received) at 7:35 PM identified she was informed Person #4 (a co- conservator) requested to bring Resident #1 to Person's #1 home (for a leave of absence). The note indicated the DON and the Medical Director were concerned for Resident #1's safety, given Person #1's threat to kill Resident #1 and him/herself several weeks ago, warranting police intervention. The external State protective agency and corporate legal were updated. The Medical Director made the decision to deny Person #4's request, based on a priority for Resident #1's safety. A virtual visit was provided with Person #4, and Person #4 expressed understanding. A facility email addressed to SW #1 and the Administrator sent from the external State protective agency case worker (Person #3), dated 4/10/2026 at 11:14 AM, identified that Person #2/co-conservator had concerns that if Person #1/co-conservator took Resident #1 out on a leave of absence (LOA), the resident would not return. The case worker identified the abuse/neglect division of her agency had recommended no unsupervised contact between Person #1 and Resident #1. A facility email addressed to the Administrator and SW #1 from the case worker dated 4/10/2026 at 11:31 AM identified Person #2 was worried about a murder/suicide with Person #1 and Resident #1. The case worker indicated she was working to have Person #1 removed from the co-conservator. A facility email by the DON sent by the Administrator to the case worker dated 4/10/2025 at 1:51 PM identified APRN #2 (facility psychiatric APRN) had spoken to the case worker and Person #2. APRN #2 had reported to the DON that Person #1 had the means and a plan (for the murder/suicide). The facility had contacted the local police who had advised that Person #1 was not allowed on the facility property anymore. A police case report dated 4/10/2026 identified at approximately 1:01 PM, they were dispatched to Resident #1's facility for a report of a suspicious incident. Upon arrival, the officer was met by the DON, the Administrator and Person #1. Person #1 was about to leave the facility and (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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 Note: The nursing home is disputing this citation.	the officer requested he/she to standby. The report indicated that Person #2 had reported that Person #1 had verbalized wanting to end Resident #1's misery by injecting Resident #1 with Insulin the next time Person #1 visited the facility. After the facility was notified, Person #1 arrived at the facility. The officer questioned Person #1 why the facility would be concerned about his/her visitation. Person #1 stated he/she did not want to explain, did not want to speak to the officer and wanted to exercise his/her fifth amendment rights, and was uncooperative. The Officer informed Person #1 that he/she was trespassed from the facility and surrounding premises, would be arrested if he/she returned and requested Person #1 to leave and Person #1 left the premises without incident. Review of the State Agency FLIS reportable event on-line website failed to identify the State Agency was notified of the alleged threat when they became aware on 4/10/2026. Review failed to identify the State Agency had been notified on or after 4/10/2026. Interview with the DON on 5/11/2026 at 11:30 AM identified she was notified on 4/10/2026 via an email from the case worker that Person #2/co-conservator had expressed concern regarding Person #1 may harm, commit a murder/suicide with Resident #1. Person #1 had requested to take Resident #1 on a LOA to visit his/her father and there was a possibility that Person #1 would attempt to harm Resident #1 and then kill him/herself. The facility psychiatric APRN (APRN #2) followed up regarding the concern and identified Person #1 was stockpiling Insulin for an alleged planned murder/suicide. APRN #2 indicated Person #1 had the means and a credible plan, and the DON contacted the police. The DON stated she did not notify the State Agency because it was an unsubstantiated threat made by a third party. Although the DON stated an allegation of abuse should be reported the State Agency, and APRN #2 had advised the threat was credible, and local police were involved, the DON stated she investigated the allegation and she should have notified the State Agency first and then completed the investigation. Interview with APRN #2 on 5/11/2026 at 12:12 PM identified the facility was notified of a possible murder/suicide plan. APRN #2 contacted the case worker and the case worker indicated that about two (2) weeks prior to the 4/10/2026 email, Person #2 had notified the case worker that Person #1 had access to insulin and expressed concern about Resident #1's safety when on an LOA for a possible murder/suicide, and Person #2 requested Resident #1 not be allowed to be alone with Person #1. APRN #2 stated Person #1 had access to Insulin, and had a stockpile of Insulin. APRN #2 stated she also spoke with Person #2 who made the allegation to the case worker, and Person #2 indicated Person #1 had access to Insulin. APRN #2 identified she had a conference call with the DON to discuss the issue on 4/10/2026 and the DON agreed that there was a concern for potential physical harm to Resident #1 and the DON was going to contact the police. Subsequent to the surveyor's inquiry, the facility submitted a reportable event (RE) form to the State Agency on 5/11/2026 (32 days after the email with the threat was received by the facility) regarding the threat received on 4/10/2026. The facility Abuse Policy directed in part, that Abuse was defined as the willful infliction of injury or punishment resulting in physical harm. The Policy further directed, to submit an online report to DPH (State Agency) within two (2) hours of notification.

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Apple Rehab Cromwell	156 Berlin Road Cromwell, CT 06416

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for wounds, the facility failed to ensure a thorough investigation was completed for an allegation of abuse as per facility policy. The findings include: Resident #1 was admitted with diagnoses that included diabetes, autism, and acquired absence of right toes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3), indicative of severe cognitive impairment, and was independent for transfers and mobility. A resident care plan (RCP) dated 1/28/2026 identified a risk for skin issues due to picking and scratching and can be verbally and/or physically aggressive. Interventions directed family members (Person #1) liked to keep door closed (when visiting) to decrease distractions and noise. Record review identified Person #1, Person #2 and Person #4 were co-conservators for Resident #1. A nursing note dated 4/10/2026 at 2:12 PM, written by the DON, identified Person #1 was no longer allowed in the building. A body audit was done without any changes noted to the skin. Resident #1 appeared relaxed and following simple commands. The door to the room was open at this time. Medical Director also saw Resident #1 on 4/10/2026. Staff were notified Person #1 was not allowed on the premises. A physician progress note, written by the Medical Director dated 5/8/2026 (29 days after the email was received) at 7:35 PM identified she was informed Person #4 (a co- conservator) requested to bring Resident #1 to Person's #1 home (for a leave of absence). The note indicated the DON and the Medical Director were concerned for Resident #1's safety, given Person #1's threat to kill Resident #1 and him/herself several weeks ago, warranting police intervention. The external State protective agency and corporate legal were updated. The Medical Director made the decision to deny Person #4's request, based on a priority for Resident #1's safety. A virtual visit was provided with Person #4, and Person #4 expressed understanding. A facility email addressed to SW #1 and the Administrator sent from the external State protective agency case worker (Person #3), dated 4/10/2026 at 11:14 AM, identified that Person #2/co-conservator had concerns that if Person #1/co-conservator took Resident #1 out on a leave of absence (LOA), the resident would not return. The case worker identified the abuse/neglect division of her agency had recommended no unsupervised contact between Person #1 and Resident #1. A facility email addressed to the Administrator and SW #1 from the case worker dated 4/10/2026 at 11:31 AM identified Person #2 was worried about a murder/suicide with Person #1 and Resident #1. The case worker indicated she was working to have Person #1 removed from the co-conservator. A facility email by the DON sent by the Administrator to the case worker dated 4/10/2025 at 1:51 PM identified APRN #2 (facility psychiatric APRN) had spoken to the case worker and Person #2. APRN #2 had reported to the DON that Person #1 had the means and a plan (for the murder/suicide). The facility had contacted the local police who had advised that Person #1 was not allowed on the facility property anymore. Interview with APRN #2 on 5/11/2026 at 12:12 PM identified the facility was notified of a possible murder/suicide plan. APRN #2 contacted the case worker and the case worker indicated that about two (2) weeks prior to the 4/10/2026 email, Person #2 had notified the case worker that Person #1 had access to insulin and expressed concern about Resident #1's safety when on an LOA for a possible murder/suicide, and Person #2 requested Resident #1 not be allowed to be alone with Person #1. APRN #2 stated Person #1 had access to Insulin, and had a stockpile of Insulin. APRN #2 stated she also spoke with Person #2 who made the allegation to the case worker, and Person #2 indicated Person #1 had access to Insulin. APRN #2 identified she had a conference call with the DON to discuss the issue on 4/10/2026 and the DON agreed that there was a concern for potential physical harm to Resident #1 and the DON was going to contact the police. Interview with the DON on 5/11/2026 (32 days after the threat was made) at 11:30 AM identified the facility did not have a local police report regarding the allegation made on 4/10/2026. Interview identified although (continued on next page)

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Apple Rehab Cromwell	156 Berlin Road Cromwell, CT 06416

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the DON was aware of the allegation of a threat of harm to Resident #1, the DON indicated she did not complete an incident report, or have any documentation of an investigation completed. The DON stated she had the email dated 4/10/2026 and had discussions with the Administrator, SW and APRN #2, but did not have any additional staff interviews or investigation completed. Additional interview with the DON on 5/13/2026 at 9:00 AM identified that on 4/10/2026, the corporate office had told her to obtain the police report, but she had forgotten to do so. Subsequent to surveyor request, the facility obtained the police report. A police case report dated 4/10/2026 identified at approximately 1:01 PM, they were dispatched to Resident #1's facility for a report of a suspicious incident. Upon arrival, the officer was met by the DON, the Administrator and Person #1. Person #1 was about to leave the facility and the officer requested he/she to standby. The report indicated that Person #2 had reported that Person #1 had verbalized wanting to end Resident #1's misery by injecting Resident #1 with Insulin the next time Person #1 visited the facility. After the facility was notified, Person #1 arrived at the facility. The officer questioned Person #1 why the facility would be concerned about his/her visitation. Person #1 stated he/she did not want to explain, did not want to speak to the officer and wanted to exercise his/her fifth amendment rights, and was uncooperative. The Officer informed Person #1 that he/she was trespassed from the facility and surrounding premises, would be arrested if he/she returned and requested Person #1 to leave and Person #1 left the premises without incident. Review of the State Agency FLIS reportable event on-line website failed to identify a reportable event was submitted to the State Agency. Interview with the DON on 5/11/2026 at 11:30 AM failed to identify the facility completed an investigation, to include staff interviews with signed staff statements. Additionally, the DON could not produce a facility accident and incident report, any involved party statements besides the email chain or any other documented information in regard to the allegation in facility documentation or the resident's medical record. Review of facility Abuse Policy, directed in part, an allegation of abuse by a staff member, visitor, family member or resident must be reported immediately to a facility supervisor who reports it to the Administrator and DON. Further, the Administrator or DON initiate an investigation.

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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 Note: The nursing home is disputing this citation.	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 wounds, the facility failed to ensure the clinical record was complete and accurate to include documentation of a threat of harm to a resident. The findings include: Resident #1 was admitted with diagnoses that included diabetes, autism, and acquired absence of right toes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3), indicative of severe cognitive impairment, and was independent for transfers and mobility. A resident care plan (RCP) dated 1/28/2026 identified a risk for skin issues due to picking and scratching and can be verbally and/or physically aggressive. Interventions directed family members (Person #1) liked to keep door closed (when visiting) to decrease distractions and noise. Record review identified Person #1, Person #2 and Person #4 were co-conservators for Resident #1. A nursing note dated 4/10/2026 at 2:12 PM, written by the DON, identified Person #1 was no longer allowed in the building. A body audit was done without any changes noted to the skin. Resident #1 appeared relaxed and following simple commands. The door to the room was open at this time. Medical Director also saw Resident #1 on 4/10/2026. Staff were notified Person #1 was not allowed on the premises. Additional record review failed to identify why Person #1 was not allowed to visit. A physician progress note, written by the Medical Director dated 5/8/2026 (29 days after the email was received) at 7:35 PM identified she was informed Person #4 (a co- conservator) requested to bring Resident #1 to Person's #1 home (for a leave of absence). The note indicated the DON and the Medical Director were concerned for Resident #1's safety, given Person #1's threat to kill Resident #1 and him/herself several weeks ago, warranting police intervention. The external State protective agency and corporate legal were updated. The Medical Director made the decision to deny Person #4's request, based on a priority for Resident #1's safety. A virtual visit was provided with Person #4, and Person #4 expressed understanding. A facility email addressed to SW #1 and the Administrator sent from the external State protective agency case worker (Person #3), dated 4/10/2026 at 11:14 AM, identified that Person #2/co-conservator had concerns that if Person #1/co-conservator took Resident #1 out on a leave of absence (LOA), the resident would not return. The case worker identified the abuse/neglect division of her agency had recommended no unsupervised contact between Person #1 and Resident #1. A facility email addressed to the Administrator and SW #1 from the case worker dated 4/10/2026 at 11:31 AM identified Person #2 was worried about a murder/suicide with Person #1 and Resident #1. The case worker indicated she was working to have Person #1 removed from the co-conservator. A facility email by the DON sent by the Administrator to the case worker dated 4/10/2025 at 1:51 PM identified APRN #2 (facility psychiatric APRN) had spoken to the case worker and Person #2. APRN #2 had reported to the DON that Person #1 had the means and a plan (for the murder/suicide). The facility had contacted the local police who had advised that Person #1 was not allowed on the facility property anymore. A police case report dated 4/10/2026 identified at approximately 1:01 PM, they were dispatched to Resident #1's facility for a report of a suspicious incident. Upon arrival, the officer was met by the DON, the Administrator and Person #1. Person #1 was about to leave the facility and the officer requested he/she to standby. The report indicated that Person #2 had reported that Person #1 had verbalized wanting to end Resident #1's misery by injecting Resident #1 with Insulin the next time Person #1 visited the facility. After the facility was notified, Person #1 arrived at the facility. The officer questioned Person #1 why the facility would be concerned about his/her visitation. Person #1 stated he/she did not want to explain, did not want to speak to the officer and wanted to exercise his/her fifth amendment rights, and was uncooperative. The Officer informed Person #1 that he/she was trespassed from the facility and surrounding premises, would be arrested if he/she (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	returned and requested Person #1 to leave and Person #1 left the premises without incident. Record review failed to identify any documentation on 4/10/2026 of the circumstances surrounding the prohibition of Person #1's to be allowed in the facility. Additional review failed to identify any documentation regarding the threat by Person #1 to kill Resident #1 and him/herself. Interview with APRN #2 on 5/11/2026 at 12:12 PM identified the facility was notified of a possible murder/suicide plan. APRN #2 contacted the case worker and the case worker indicated that about two (2) weeks prior to the 4/10/2026 email, Person #2 had notified the case worker that Person #1 had access to insulin and expressed concern about Resident #1's safety when on an LOA for a possible murder/suicide, and Person #2 requested Resident #1 not be allowed to be alone with Person #1. APRN #2 stated Person #1 had access to Insulin, and had a stockpile of Insulin. APRN #2 stated she also spoke with Person #2 who made the allegation to the case worker, and Person #2 indicated Person #1 had access to Insulin. APRN #2 identified she had a conference call with the DON to discuss the issue on 4/10/2026 and the DON agreed that there was a concern for potential physical harm to Resident #1 and the DON was going to contact the police. Interview with the DON on 5/11/2026 at 11:30 AM identified she was unable to provide documentation in the medical record regarding the allegation of a threat of harm to Resident #1 made on 4/10/2026. Interview identified the record should have included documentation of the threat and why Person #1 was not allowed to visit. Interview failed to identify why the record did not include the documentation. The facility Abuse Policy directed in part, an allegation of abuse by a staff member, visitor, family member or resident must be reported immediately to a facility supervisor who then reports it to the DON and Administrator. The Policy further directed, nursing staff to document a description of the incident in the resident's record. The facility policy Nursing Documentation directed in part that documentation should be completed as soon as possible after a significant event occurs ideally on the same shift.