STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075388	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Avon	220 Scoville Road Avon, CT 06001

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation, facility policy and interviews for one of three residents (Resident #6) reviewed for abuse, the facility failed to ensure the State Agency was notified timely of an allegation of abuse. The findings include: Resident #6 was admitted with diagnoses that included borderline personality, post-traumatic stress disorder. A resident care plan (RCP) dated 7/25/2024 identified Resident #6 exhibited accusatory behaviors and poor impulse control towards staff's care. Interventions directed to approach in a clam manner, explain all procedures and medications before administering and do not engage if resident escalates or becomes accusatory. A quarterly MDS assessment dated [DATE] identified Resident #6 had a BIMS of 15 meaning he/she was alert and oriented, and was independent with ALDs and mobility. A facility grievance form dated 8/25/2024 identified Resident #6 reported that the weekend supervisor had recorded her/him on his cell phone saying Resident #6 had psychological problems. Interview and review of the grievance with the DON on 10/28/2024 at 11:30 AM identified that she had reviewed and investigated the grievance reported by Resident #6 on 8/25/2026. The DON stated she did not consider the grievance to be an allegation of abuse and she did not report that allegation to the State Agency. Subsequent to inquiry, the facility submitted the allegation to the State Agency. The facility policy Protecting Resident Privacy and Prohibiting Mental Abuse directed in part, each resident had the right to be free from all types of abuse included mental abuse. The Policy further indicated, related to photos and audio/video recordings by staff, that the facility defined mental abuse to include abuse that is facilitated or caused by nursing home staff taking or using recordings in any manner to demean a resident. The facility policy Abuse/Resident in part, directed that upon reports of an allegation of abuse or mistreatment, the DON, Administrator or designed will immediately conduct an investigation and submit a notification to the state survey agency within two (2) hours.

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