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	05/07/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm 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 reviews, review of facility documentation, facility policies, and interviews for one (1) of three (3) sampled residents (Resident #3) who were required supervision during meals, the facility failed to follow the physician's order and provide the one to one (1:1) supervision when food was delivered to Resident #3 to prevent a choking episode. The findings include: Resident #3's diagnoses included bipolar disorder, diabetes mellitus, asthma, depression and anxiety. The initial Resident Care Plan dated 2/7/25 identified non-compliance related to diet, drinking thin liquids when on a nectar thick liquid diet. Interventions directed to educate the resident on the importance of following the physician's order while respecting resident rights and observing any untoward effects of non-compliance, document and report to the provider. The admission Minimum Data Set assessment dated [DATE] identified Resident #3 had no memory recall deficits and required supervision with eating. The speech therapy evaluation and plan of treatment dated 4/14/25 identified Resident #3 was referred secondary to a recent onset of oropharyngeal dysphagia status post an Anterior Cervical Discectomy and Fusion (ACDF), a surgical procedure to treat neck pain and nerve compression by removing damaged discs and fusing the vertebrae. The clinical impression from the swallow evaluation revealed Resident #3 presented with mild oropharyngeal dysphagia and cognitive deficits, delay in recall, attention, executive functioning and language fluency. The swallow evaluation recommendations were as follows: dysphagia level 3 diet, thin liquids, 1:1 supervision and assist for feeding with cues for small bites, small sips and slow rate. A physician's order dated 4/14/25 directed to provide a carbohydrate-controlled diet, Dysphagia Advanced/Level 3 texture (foods are soft enough to be chewed and swallowed with minimal difficulty), thin liquids consistency with one to one (1:1) supervision, and assist for feeding with small bites, small sips and alternate solids with liquids. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 4/20/25 at 1:21 PM identified at 11:55 AM Resident #3 was noted to be having a hard time breathing. The note indicated staff sat Resident #3 up with the head of the bed at ninety (90) degrees however Resident #3 continued to struggle, and was not able to speak when asked if he/she had eaten the dessert (cake) that had been served with lunch. The note identified abdominal thrusts were given with no progress, 911 was called, the ambulance arrived, and Resident #3 was transferred to the hospital. The nurse's note dated 4/21/25 at 3:52 AM identified Resident #3 returned to the facility at approximately 12:10 AM with no new orders. The facility summary report dated 4/23/25 identified on 4/20/25, after being boosted up in bed, Resident #3 was given a piece of moist cake prior to lunch being served, Resident #3 was noted to be having a hard time breathing and was transferred to the hospital. The summary report identified Resident #3 had a hospital diagnosis of aspiration. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 5/7/25 at 12:04 PM identified Resident #3 had an order in place for supervision during meals. LPN #1 explained when a resident required 1:1 supervision with meals, a staff member must be present during the entire meal. LPN #1 identified at the time of the event on 4/20/25, staff were in the process of passing out the lunch meal beginning with the dessert, which the nurse aide left in front of Resident #3 and staff were going to provide supervision after all the lunch trays were delivered. Interview with 7AM-3PM nurse aide, Nurse Aide (NA) #1, on 5/7/25 at 1:37 PM identified on 4/20/25 she passed out the dessert (a piece of cake) to Resident #3 and left it on the overbed table. NA #1 explained she did not stay with Resident #3 after she put the piece of cake on the overbed table and continued to pass out desserts to other residents on the unit. Interview and clinical record review with the Director of Nursing (DON) on 5/7/25 at 1:45 PM identified on 4/20/25, Resident #3 was provided with a piece of cake without the benefit of a staff member present for supervision. The DON indicated that when a resident has an order for 1:1 feeding, the facility policy is a staff member needs to always be in the room during a meal. The DON identified the facility policy and physician's order were not followed. Review of the facility policy titled Feeding, last updated 12/7/23, directed, in part, if a resident is a 1:1 feed, a staff person must always be with this resident when feeding and follow any specific feeding techniques that are recommended. Review of facility documentation identified the facility implemented an action plan: staff education was initiated on 4/21/2025 and included directing staff that all residents' diets to be reviewed and consistency checked during each meal tray disbursement, all residents who require supervision will have supervision provided, and random audits of all residents identified as a dysphagia level 3 diet who require supervision will receive the appropriate diet and supervision. Audits will continue for at least 30 days, and all data will be reviewed at the next facility QAPI meeting. Based on review of facility documentation, past non-compliance was identified.