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	12/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 #1) reviewed for abuse, the facility failed ensure the Resident #1 was free from verbal mistreatment. The findings include: Resident #1 was admitted with diagnoses that included major depression, end stage kidney disease and heart failure. The Resident Care Plan (RCP) dated 3/14/2022 identified Resident #1 often refused treatments, hoarded items and refused out of bed. Interventions directed two (2) staff in attendance when providing care and encourage appropriate storage of items. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was alert and oriented and required extensive assistance for bed mobility. A facility reportable event (RE) form dated 4/28/2022 identified an incident of staff-to-resident abuse without injury. The form identified on 4/17/2022, a staff member (Housekeeper #1) was witnessed to have gotten into an argument with Resident #1 and used curse words towards the resident. A facility RE summary dated 5/18/2022 identified the Housekeeper #1 used profanity towards Resident #1 and the facility terminated her employment. Interview and review of his facility statement with the Director of Maintenance (DM) on 12/05/2025 at 12:45 PM identified on 4/23/2022 he observed Resident #1 became upset with Housekeeper #1, and was yelling that the bedside table had been moved during cleaning demanding it be put back. Housekeeper #1 moved the bedside table as requested. On 4/25/2025, the DM observed Housekeeper #1 in Resident #1's room and Housekeeper #1 told Resident #1 that if he/she treated her the way he/she had treated her the last time (on 4/23/2022) then Housekeeper #1 would no longer clean the room. The DM stated Resident #1 and Housekeeper #1 began to argue, swearing at each other with Housekeeper #1 calling Resident #1 a lazy momma b---ch. The DM requested Housekeeper #1 leave the room and he notified the Administrator the next day (on 4/26/2027)and stated he should have notified the Administrator immediately after his observation as it was considered verbal abuse. Interview and record review with the DON on 12/2/2025 at 1:15 PM identified if a staff member reported they observed a staff member arguing with a Resident and then calling that Resident a lazy b---ch, that it would be considered verbal abuse, and the facility policy should be followed to include suspending the employee. Interview and review of facility investigative documents with the Administrator on 12/5/2025 at 1:25 PM identified that calling Resident #1 a lazy momma b---ch, would be considered an incident of verbal abuse. The Administrator stated they were unable to obtain a statement from Housekeeper #1, and her employment had been terminated. A review of the Housekeeper #1's employee file identified that on 5/5/2022 she identified a notation that she may have used the word b-tch when addressing Resident #1. Additional documentation identified that the incident occurred on 4/25/2025. The facility Abuse Policy, directed in part, that any kind of abuse or mistreatment is strictly prohibited. Verbal abuse was defined as the use of oral, written or gestured language that includes derogatory or threatening terms directed at a resident.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **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 #1) reviewed for abuse, the facility failed to ensure an employee was removed from the schedule after she was observed using inappropriate language. The findings include:Resident #1 was admitted with diagnoses that included major depression, end stage kidney disease and heart failure. The Resident Care Plan (RCP) dated 3/14/2022 identified Resident #1 often refused treatments, hoarded items and refused out of bed. Interventions directed two (2) staff in attendance when providing care and encourage appropriate storage of items. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was alert and oriented and required extensive assistance for bed mobility. A facility reportable event (RE) form dated 4/28/2022 identified an incident of staff-to-resident abuse without injury. The form identified on 4/17/2022, a staff member (Housekeeper #1) was witnessed to have gotten into an argument with Resident #1 and used curse words towards the resident. A facility RE summary dated 5/18/2022 identified the Housekeeper #1 used profanity towards Resident #1 and the facility terminated her employment. Interview and review of his facility statement with the Director of Maintenance (DM) on 12/05/2025 at 12:45 PM identified on 4/23/2022 he observed Resident #1 became upset with Housekeeper #1, and was yelling that the bedside table had been moved during cleaning demanding it be put back. Housekeeper #1 moved the bedside table as requested. On 4/25/2025, the DM observed Housekeeper #1 in Resident #1's room and Housekeeper #1 told Resident #1 that if he/she treated her the way he/she had treated her the last time (on 4/23/2022) then Housekeeper #1 would no longer clean the room. The DM stated Resident #1 and Housekeeper #1 began to argue, swearing at each other with Housekeeper #1 calling Resident #1 a lazy momma b---ch. The DM requested Housekeeper #1 leave the room and he notified the Administrator the next day (on 4/26/2027). The DM stated he was unclear as to the specific disciplinary action needed for Housekeeper #1 and stated he did not suspend the housekeeper. When he notified the Administrator, a 3-day suspension be put into place and Housekeeper #1 never returned to the facility. Interview and record review with the DON on 12/2/2025 at 1:15 PM identified if a staff member reported they observed a staff member arguing with a Resident and then calling that Resident a lazy b---ch, that it would be considered verbal abuse, and the facility policy should be followed to include suspending the employee. Interview and review of facility investigative documents with the Administrator on 12/5/2025 at 1:25 PM identified that calling Resident #1 a lazy momma b---ch, would be considered an incident of verbal abuse. The Administrator stated the employee should have been suspended immediately and failed to identify why the employee was not removed from the schedule. A review of the Housekeeper #1's employee file identified that on 5/5/2022 she identified a notation that she may have used the word b-tch when addressing Resident #1. Additional documentation identified that the incident occurred on 4/25/2025. The facility Abuse Policy, directed in part, that any kind of abuse or mistreatment is strictly prohibited. Verbal abuse was defined as the use of oral, written or gestured language that includes derogatory or threatening terms directed at a resident. Further, the Policy directed after an allegation of abuse, an employee was to be removed from the schedule pending the results of the investigation.

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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. (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 Note: The nursing home is disputing this citation.	**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 #1) reviewed for abuse and neglect, the facility failed to ensure staff reported an allegation of abuse/mistreatment timely, and the facility failed to ensure the State Agency was notified timely of an allegation of mistreatment after staff reported an allegation. The findings include:Resident #1 was admitted with diagnoses that included major depression, end stage kidney disease and heart failure. The Resident Care Plan (RCP) dated 3/14/2022 identified Resident #1 often refused treatments, hoarded items and refused out of bed. Interventions directed two (2) staff in attendance when providing care and encourage appropriate storage of items. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was alert and oriented and required extensive assistance for bed mobility. A facility reportable event (RE) form dated 4/28/2022 identified an incident of staff-to-resident abuse without injury. The form identified on 4/17/2022, a staff member (Housekeeper #1) was witnessed to have gotten into an argument with Resident #1 and used curse words towards the resident. A facility RE summary dated 5/18/2022 identified the Housekeeper #1 used profanity towards Resident #1 and the facility terminated her employment. Interview and review of his facility statement with the Director of Maintenance (DM) on 12/05/2025 at 12:45 PM identified on 4/23/2022 (Saturday) he observed Resident #1 became upset with Housekeeper #1, and was yelling that the bedside table had been moved during cleaning demanding it be put back. Housekeeper #1 moved the bedside table as requested. On 4/25/2025 (Monday), the DM observed Housekeeper #1 in Resident #1's room and Housekeeper #1 told Resident #1 that if he/she treated her the way he/she had treated her the last time (on 4/23/2022) then Housekeeper #1 would no longer clean the room. The DM stated Resident #1 and Housekeeper #1 began to argue, swearing at each other with Housekeeper #1 calling Resident #1 a lazy momma b---ch. The DM requested Housekeeper #1 leave the room and he notified the Administrator the next day (on 4/26/2022, Tuesday) because the Administrator was unavailable on 4/25/2022. Further, the DM stated he should have informed the Administrator immediately after his observations as it was considered verbal abuse. Interview and record review with the DON on 12/2/2025 at 1:15 PM identified if a staff member reported they observed a staff member arguing with a Resident and then calling that Resident a lazy b---ch, that it would be considered verbal abuse, and it should be reported immediately. The facility policy should be followed to include reporting the incident immediately. Interview and review of facility investigative documents with the Administrator on 12/5/2025 at 1:25 PM identified that calling Resident #1 a lazy momma b---ch, would be considered an incident of verbal abuse. The Administrator stated theDM should have notified the Administrator immediately when he observed the interaction. A review of the Housekeeper #1's employee file identified that on 5/5/2022 she identified a notation that she may have used the word b-tch when addressing Resident #1. Additional documentation identified that the incident occurred on 4/25/2025. a. Review of the State Agency reportable events identified the State Agency was notified of an incident dated 4/28/2025 that indicated the incident occurred on 4/28/2025 at 11:30 AM. Further review failed to identify the State Agency was notified of the incident that occurred on 4/25/2025 as reported by the DM. Interview and review of his facility statement with the Director of Maintenance (DM) on 12/05/2025 at 12:45 PM identified the incident with Housekeeper #1 occurred on Monday, 4/25/2022 and he notified the Administrator on Tuesday, 4/26/2022 (the day after it occurred). He stated that the incident did not occur on 4/28/2022. Interview and review of facility investigative documents with the Administrator on 12/5/2025 at 1:25 PM identified although the incident between Resident #1 and Housekeeper #1 occurred on 4/25/2022 and the DM notified the Administrator #2 of the incident on 4/26/2022, the State Agency was not notified until 4/28/2022 (3 days after the incident occurred and 2 days after it was reported to Administrator #2). The Administrator stated the State Agency should have been notified as soon as it was reported by the DM. The facility Abuse Policy, directed in part, that any kind of abuse or mistreatment is strictly prohibited. Verbal abuse was defined as the use of oral, written or gestured language that includes derogatory or threatening terms directed at a resident. After an allegation of abuse, an employee was to be removed from the schedule pending the results of the investigation. Further, the Policy directed an online report will be submitted to the State Agency within two (2) hours of notification.