

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Apple Rehab Avon		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure staff monitored the resident's whereabouts timely, and the resident was last observed by staff at approximately 6:30 PM and identified missing at 11:48 PM. The findings include: Resident #1's diagnoses included diabetes mellitus and paranoid schizophrenia. Record review identified Resident #1 had a court appointed conservator for person (COP). Review of the Capacity to Meet Minimal Basic Needs assessment dated [DATE] identified Resident #1 did not have the capacity to meet his/her minimal basic needs in the community. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen (12/15), was cognitively intact, had no wandering behaviors and ambulated independently. The Resident Care Plan dated 5/15/26 identified a risk for changes in mood state and behaviors related to paranoid schizophrenia. Interventions directed monitor symptoms, delusions, hallucinations, periods of manic mood and follow up with psychiatry as indicated. Social services note dated 5/18/26 at 1:35 PM by SW #1 identified Resident #1 requested multiple times during the morning to return home. SW #1 attempted to educate Resident #1 regarding safety concerns associated with a leave of absence (LOA) and the need for involvement of his/her COP. Resident #1 adamantly denied needing a COP and became verbally aggressive toward SW #1 while pacing the hallways. A call was made with a message left to request assistance from a family member to obtain personal belongings from the apartment, and a referral was placed for psychiatric follow up. A facility incident report and investigation dated 5/19/26 at 7:00 PM identified Resident #1 went on unauthorized leave. The investigation's timeline identified at 11:48 PM, NA #1 reported to LPN #2 that Resident #1 was not in his/her room they searched the dining room and frequent/common areas. When Resident #1 was not located, a Dr. Hunt (Code for Missing Resident) was called immediately, per facility policy and a wider search including the grounds was conducted without locating Resident #1, and at 11:59 PM, local police were notified. LPN #2 reached Resident #1 by phone at 12:08 AM and Resident #1 stated he/she had called an Uber and was home safe, understood the risks of leaving the facility Against Medical Advice (AMA), and knew how to call 911 if needed. Review of the local police report dated 5/19/26 at 11:55 PM identified Police Officer (PO) #1 and #2 responded to the facility report of missing Resident #1, and was informed Resident #1 was last seen at approximately 6 or 6:30 PM (approximately 5 hours and 18 minutes before identified missing). Resident #1 was located at his/her apartment approximately 11 miles away. The local PO spoke with Resident #1 via phone and Resident #1 indicated he/she left the facility at approximately 7 PM through the front door and was picked up by a friend. A nursing note dated 5/20/2026 at 10:23 AM written by the DON identified Resident #1 was not returning to the facility and was staying at his/her apartment and was choosing an AMA discharge. Local police performed a wellness check and identified Resident #1 was safe. Review of the facility investigation identified facility security video indicated Resident #1 left through the front door at 7:06 PM (4 hours and 48 minutes prior to staff identifying Resident #1 was missing). Interview with the Director of Nursing (DON) and RN #2/Corporate Nurse on 6/5/26 at 1:55 PM identified the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation was that nursing staff conduct rounds on all residents at least every two hours. Although Resident #1 was reported to last be observed by staff about 6:30 PM, interview failed to identify why staff did not identify Resident #1 was missing until 11:48 PM (5 hours and 18 minutes later). A facility policy on monitoring resident whereabouts was not provided for surveyor review.		