

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2023
NAME OF PROVIDER OR SUPPLIER  Apple Rehab Uncasville		STREET ADDRESS, CITY, STATE, ZIP CODE  5 Richard Brown Drive Uncasville, CT 06382	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44675</b></p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of two (2) residents, (Resident #1 and #2) reviewed for abuse, the facility failed to ensure conserved residents unable to provide consent were free from sexual abuse. The findings include:</p> <p>1. Resident #1 was admitted to the facility with diagnoses that included dementia, major depressive disorder and macular degeneration. Review of the Court of Probate document identified Resident #1 was appointed a conservator of person and estate on 9/19/19.</p> <p>A physician's order dated 12/17/22 directed transfers and ambulation with assistance of one with rolling walker due to fall risk.</p> <p>The care plan dated 8/15/23 identified Resident #1 had impaired memory and cognition due to dementia with interventions that included to allow Resident #1 to keep familiar items from home in his/her room, administer medications as ordered and when possible, maintain consistent caregivers.</p> <p>The quarterly MDS dated [DATE] identified Resident #1 had severely impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance of one staff with activities of daily living (ADL's).</p> <p>2. Resident #2 was admitted to the facility with diagnoses that included epilepsy and adjustment disorder. Review of the Court of Probate document identified Resident #2 was involuntary appointed a conservator of person and estate on 1/9/23.</p> <p>The care plan dated 8/29/23 identified Resident #2 had a problematic way the resident acted characterized by inappropriate sexual behavior related to inappropriate remarks with interventions included to distract the resident, if possible, avoid conversation that could of led to inappropriate behavior, explain and explore with the resident the effects of his/her behavior on the other residents and staff and intermittent supervision in recreational programs.</p> <p>A physician's order dated 10/23/23 directed Resident #2 was independent for transfers and ambulation with supervision and rolling walker.</p> <p>The quarterly MDS dated [DATE] identified Resident #2 had severely impaired cognition, was always continent of urine and bowel and required supervision with activities of daily living (ADL's).</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a) A nursing note written by RN #1 on 11/7/23 at 10:52 PM identified at 5:58 PM Resident #1 was observed in Resident #2's room, lying in his/her bed naked from the waist down. Resident #2 was naked from the waist down leaning down into Resident #1's private area. RN#1 immediately got in between the two residents and separated them. She pressed the call button while yelling for another nurse to come. She stayed in the room while the other nurse called the supervisor and DNS and other staff came to help remove the other resident from the room. Resident #1 was placed at the nursing station for 1:1 monitoring. The MD and Resident #1's family were called. Resident #1 stated h/she not upset. Resident #1 had baseline confusion and was not able to make cognitive decisions.</p> <p>A nursing note written by RN #1 on 11/7/23 at 11:35 PM identified she went into Resident #2's room at 5:58 PM for his/her medications and noticed the door was closed. When she tried to open the door, there was an empty wheelchair blocking it and the lights were off. She saw Resident #1 lying in Resident #2's bed naked from the waist down, and Resident #2 was naked from the waist down leaning down towards Resident #1's private area. She immediately got in between the two residents and separated them. She pressed the call button while yelling for another nurse to come. She stayed in the room while the other nurse called the supervisor and DNS and other staff came to help removed the other resident from the room.</p> <p>Review of the Accident &amp; Incident (A&amp;I) form dated 11/7/23 identified at 5:58 PM Resident #1 was discovered in Resident #2's room undressed from the waist down and Resident #2 had his/her head in Resident #1's private area</p> <p>A nursing note written by RN #2 on 11/8/23 at 7:30 AM identified she completed a physical exam of Resident #1. Resident #1 had no noted pain, bruising, or injuries observed to his/her private areas. Resident #1 did not recall the incident.</p> <p>A nursing note written by RN #2 on 11/8/23 at 10:00 AM identified she spoke with Resident #1's family member that morning as they have been unable to reach Resident #1's conservator. Resident #1's family member was initially undecided about sending Resident #1 to the ED for evaluation due to his/her dementia and fear of Resident #1 becoming agitated. After discussion it was decided it was in Resident #1's best interest to have him/her evaluated examined. Resident #1 was medicated with Ativan prior to leaving and was calm and cooperative with the EMS staff. It further identified Resident #1 was used to be affectionate with his/her spouse, who lived in the facility up until his/her death a few weeks ago. Resident #1 may have been confused as to Resident #2's identity.</p> <p>A nursing note written by RN #2 dated 11/8/23 at 2:30 PM identified she received report from the ED that Resident #1 was examined by the medical provider and no abnormalities were noted and the resident would be returning to the facility.</p> <p>Review of the hospital ED report dated 11/8/23 identified there was no evidence of trauma on genital exam for Resident #1.</p> <p>Interview with NA #1 on 12/1/23 at 3:02 PM identified on 11/7/23 she last saw Residents' #1 and #2 in the dining room, sitting next to each other between 5:00 PM - 5:30 PM for dinner.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #1 on 12/7/23 at 12:07 PM identified on 11/7/23 she last saw Residents' #1 and #2 sitting in the foyer across from the nursing station, after dinner, 5 to 10 minutes before the event. She identified Resident #1 was sitting in a wheelchair and Resident #2 was sitting in a chair and they were not next to each other. She identified at 5:57 PM she was called to Resident #2's room where Resident #1 was observed lying in Resident #2's bed naked from the waist down and Resident #2 was observed sitting at the foot of the bed putting on his/her underpants with another nurse between them. She immediately paged the nursing supervisor and DNS. She identified RN #1 and the supervisor assessed Resident #1 and he/she denied pain, did not appear to be in distress and had no injuries identified. She identified Resident #1 went to the nursing station with her for 1:1 observation.</p> <p>Although multiple attempts made, an interview with RN #1 could not be obtained.</p> <p>Interview with the DNS on 12/1/23 at 3:47 PM identified Resident #1 and Resident #2 were both placed on 1:1 observation following the event. Resident #2's room was changed to different floor from Resident #1's. He identified Resident #1 and Resident #2 were both conserved residents and did not have permission from the conservator to engage in sexual activities. He further identified Resident #1 and Resident #2 were unable to consent to sexual activities and were not to be engaged in any sexual acts.</p> <p>Review of the Resident Abuse policy identified the purpose is to ensure each resident is treated with kindness, compassion and in a dignified manner. It directed abuse or mistreatment of any kind toward a resident is strictly prohibited.</p> <p>Review of the resident bill of rights directed residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality. It further identified residents have the right to be free from verbal, sexual, physical or mental abuse.</p>		