STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075380	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB CROMWELL	**156 BERLIN ROAD CROMWELL, CT 06416**

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** Based on review of the clinical record, interviews, and review of facility documentation, for one of four residents reviewed for abuse, (Resident #4), the facility failed to report an allegation of abuse in a timely manner. The findings include: a. Resident #4 was admitted to the facility for short term rehabilitation, with [DIAGNOSES REDACTED]. The admission assessment dated [DATE] identified Resident #4 required assistance of a mechanical lift with two staff for transfers, was partial weight bearing, was oriented to person, place, and time, and had clear speech. The care plan dated 5/28/20 identified a focus area of Activities of Daily Living (ADLs), with interventions including provide assistance of two staff for ambulation and transfers, assistance of one for toilet use. A physician's orders [REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] identified Resident #4 had no cognitive deficits, had no [MEDICAL CONDITION] or behavioral problems, and required the extensive assistance of one staff for bed mobility, transfers, and toilet use. Interview with Nurse Aide (NA) #5 on 6/26/20 at 12:42 PM identified: On 6/3/20, near the beginning of the 3:00PM to 11:00PM shift, Resident #4 called for aides for assist with toilet use. When NA #5 arrived at Resident #4's room, Resident #4 said he/she did not want to bother anyone, seemed anxious, and that was not his/her usual self. NA #5 asked Resident #4, why he/she said that? It's no bother. Resident #4 said he/she was yelled at. At that time the roommate, Resident #2 said the aide from the morning shift had told Resident #4 that it was too early to call, then the aide put on the TV and left. NA #6 had come into the room during this and both NA #5 and NA #6 went immediately to the nurse, Registered Nurse (RN) #1, and reported this to him/her. Interview with RN #1 on 6/26/20 at 1:39 PM identified: On 6/3/20 on 3:00PM to 11:00PM shift, nurse aides reported concerns about the 7:00AM to 3:00PM shift of that same day. At approximately 4:00 PM, Physical Therapy Assistant (PTA) #1 made a comment about concerns from the 7:00AM to 3:00PM shift and PTA #1 said that it had been reported to the Director of Nurses (DNS) earlier. At approximately 5:00 PM, RN #1 sent a text to the Administrator that there were resident concerns, there were complaints about Resident #2, who said he/she was afraid to call for help on first shift and so had waited until second shift, because he/she did not like how the aide had talked to his/her roommate, and that the physical therapist said it was reported to the DNS. Later in the shift, at 10:30 PM, RN #1 was told by NAs #5 and #6 that Resident #4 had been yelled at in the morning. RN #1 went to Resident #4, who did not want to talk to RN #1, and said it was nothing. RN #1 identified that Resident #4 had told an aide that he/she was yelled at. Resident #4's roommate, Resident #2 said he/she would tell what happened, and said that at 7:00 AM the aide came in and put the television on, said it was too early, and then left and came back about 11:00 AM. The next morning, 6/4/20, RN #1 gave report, and then gave a written statement. The DNS told RN #1 that he/she did not need to update the Administrator, and RN #1 told the DNS that he/she had updated the Administrator because the DNS did not interview the residents. RN #1 told the DNS that he/she needed to speak with the residents and the DNS said she/he would wait for RN #1's written report. The DNS allegedly kept saying to RN #1 that nothing was wrong. RN #1 told the DNS that he/she needed to see the residents and the DNS agreed to speak with the residents. RN #1 gave the written statement to the Administrator because the DNS was not in the office when RN #1 finished typing it. RN #1's written statement, in part, (from a copy kept by RN #1) identified that on 6/3/20 at approximately 4:00 PM it was reported to writer that residents in rooms 31, 33, 39 and 50B did not receive care when they needed it and that it was reported that Resident #4 did not get care until 2:50 PM. The next day, 6/5/20, RN #1 asked NAs #5 and #6 if they had given written statements and they reported no. RN #1 did not call the Administrator or the DNS after hearing report that Resident #2 had been yelled at because he/she had heard that the concerns were reported to the DNS and because Resident #2 did not report any issues to him/her. RN #1 did not obtain any statements on 6/3/20. Interview with NA #6 on 6/26/20 at 2:45 PM identified: In the first week of June 2020, before supper, between 3:00 PM and 5:00 PM, Resident #4's call light was on. NA #6 went in the room, and NA #5 was already in the bathroom with Resident #4. Resident #2 said that Resident #4 had gotten yelled at by the aide in the morning and told to watch TV. NA #5 and NA #6 went right then to the nurse, RN #1, and told him/her. NA #6 identified that he/she was not asked for a statement or asked about this incident at any time after that. Nurse's notes for June 2020 identified no concerns or follow-up related to any resident concerns. Review of state agency electronic reporting system failed to reflect an incident related to Resident #4 was reported until 6/26/20, subsequent to surveyor inquiry and report. Interview with the Administrator on 7/6/20 at 8:55 AM identified RN #1 failed to follow facility policy for Abuse, RN #1 should have ensured the DNS was notified immediately of any report of potential neglect or abuse. The facility policy for Abuse identified, in part, anyone having knowledge of abuse or mistreatment of [REDACTED]. The facility failed to ensure an allegation of abuse was reported in a timely manner.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility documentation, for one of four residents reviewed for abuse, (Resident #4), the facility failed to begin and complete an investigation in a timely manner. The findings include: a. Resident #4 was admitted to the facility for short term rehabilitation, with [DIAGNOSES REDACTED]. The admission assessment dated [DATE] identified Resident #4 required assistance of a mechanical lift with two staff for transfers, was partial weight bearing, was oriented to person, place, and time, and had clear speech. The care plan dated 5/28/20 identified a focus area of Activities of Daily Living (ADLs), with interventions including provide assistance of two staff for ambulation and transfers, assistance of one for toilet use. A physician's orders [REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] identified Resident #4 had no cognitive deficits, had no [MEDICAL CONDITION] or behavioral problems, and required the extensive assistance of one staff for bed mobility, transfers, and toilet use. Interview with Nurse Aide (NA) #5 on 6/26/20 at 12:42 PM identified: On 6/3/20, near the beginning of the 3:00PM to 11:00PM shift, Resident #4 called for aides for assist with toilet use. When NA #5 arrived at Resident #4's room, Resident #4 said he/she did not want to bother anyone, seemed anxious, and that was not his/her usual self. NA #5 asked Resident #4, why he/she said that? It's no bother. Resident #4 said he/she was yelled at. At that time the roommate, Resident #2 said the aide from the morning shift had told Resident #4 that it was too early to call, then the aide put on the TV and left. NA #6 had come into the room during this and both NA #5 and NA #6 went immediately to the nurse, Registered Nurse (RN) #1, and reported this to him/her. Interview with RN #1 on 6/26/20 at 1:39 PM identified: On 6/3/20 on 3:00PM to 11:00PM shift, nurse aides reported concerns about the 7:00AM to 3:00PM shift of that same day. At approximately 4:00 PM, Physical Therapy Assistant (PTA) #1 made a comment about concerns from the 7:00AM to 3:00PM shift and PTA #1 said that it had been reported to the Director of Nurses (DNS) earlier. At approximately 5:00 PM, RN #1 sent a text to the Administrator that there were resident concerns, there were complaints about Resident #2, who said he/she was afraid to call for help on first shift and so had waited until second shift, because he/she did not like how the aide had talked to his/her roommate, and that the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) physical therapist said it was reported to the DNS. Later in the shift, at 10:30 PM, RN #1 was told by NAs #5 and #6 that Resident #4 had been yelled at in the morning. RN #1 went to Resident #4, who did not want to talk to RN #1, and said it was nothing. RN #1 identified that Resident #4 had told an aide that he/she was yelled at. Resident #4's roommate, Resident #2 said he/she would tell what happened, and said that at 7:00 AM the aide came in and put the television on, said it was too early, and then left and came back about 11:00 AM. The next morning, 6/4/20, RN #1 gave report, and then gave a written statement. The DNS told RN #1 that he/she did not need to update the Administrator, and RN #1 told the DNS that he/she had updated the Administrator because the DNS did not interview the residents. RN #1 told the DNS that he/she needed to speak with the residents and the DNS said she/he would wait for RN #1's written report. The DNS allegedly kept saying to RN #1 that nothing was wrong. RN #1 told the DNS that he/she needed to see the residents and the DNS agreed to speak with the residents. RN #1 gave the written statement to the Administrator because the DNS was not in the office when RN #1 finished typing it. RN #1's written statement, in part, (from a copy kept by RN #1) identified that on 6/3/20 at approximately 4:00 PM it was reported to writer that residents in rooms 31, 33, 39 and 50B did not receive care when they needed it and that it was reported that Resident #4 did not get care until 2:50 PM. The next day, 6/5/20, RN #1 asked NAs #5 and #6 if they had given written statements and they reported no. RN #1 did not call the Administrator or the DNS after hearing report that Resident #2 had been yelled at because he/she had heard that the concerns were reported to the DNS and because Resident #2 did not report any issues to him/her. RN #1 did not obtain any statements on 6/3/20. Interview with NA #6 on 6/26/20 at 2:45 PM identified: In the first week of June 2020, before supper, between 3:00 PM and 5:00 PM, Resident #4's call light was on. NA #6 went in the room, and NA #5 was already in the bathroom with Resident #4. Resident #2 said that Resident #4 had gotten yelled at by the aide in the morning and told to watch TV. NA #5 and NA #6 went right then to the nurse, RN #1, and told him/her. NA #6 identified that he/she was not asked for a statement or asked about this incident at any time after that. Nurse's notes for June 2020 identified no concerns or follow-up related to any resident concerns. Review of state agency electronic reporting system failed to reflect an incident related to Resident #4 was reported until 6/26/20, subsequent to surveyor inquiry and report. Interview with the Administrator on 7/6/20 at 8:55 AM identified RN #1 failed to follow facility policy for Abuse, RN #1 should have ensured the DNS was notified immediately of any report of potential neglect or abuse. The facility policy for Abuse identified, in part, anyone having knowledge of abuse or mistreatment of [REDACTED]. The facility failed to ensure an investigation of an allegation of abuse was started in a timely manner.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Observe each nurse aide's job performance and give regular training.** Based on review of facility documentation and interviews, for three of three Nurse Aides (NA), (NA #1, NA #3, and NA #4), the facility failed to ensure annual performance evaluations were completed. The findings include: a. Interview with the Director of Human Resources on 6/26/20 at 11:34 AM identified that there were no performance evaluations for NA #1, with date of hire 12/1/16. The Director of Human Resources identified that the agency had not been doing evaluations and were now trying to get them done. b. Email from the Director of Human Resources on 6/26/20 at 12:32 PM identified that there were no performance evaluations for NA #3, with date of hire 5/1/13. c. Email from the Director of Human Resources on 6/26/20 at 12:40 PM identified that the most recent performance evaluations for NA #4, with date of hire 9/10/98, was from 2016. The facility policy for Performance and Review identified employees will be provided a formal and documented performance review at the end of the employee's introductory period and will endeavor to give reviews at least annually thereafter.