STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075271	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	475 High St Mystic, CT 06355

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for four (4) of six (6) residents (Residents #3, 4, 5 and 6) reviewed for abuse, the facility failed to ensure that the grievance forms were filled out and responded to per policy and failed to ensure the residents were provided support timely after allegations of abuse/mistreatment were made within the facility. The findings include: 1. Resident #3's diagnoses included anxiety disorder and depression. The Resident Care Plan (RCP) dated 10/28/24 identified Resident #3 has the potential for impaired psychosocial wellbeing related to the loss of independence and the need for assistance with interventions that included encouraging the resident to verbalize feelings and make routine daily decisions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was dependent on staff for personal hygiene, toileting, bed mobility and transfers. Interview with Resident #3 on 2/13/25 at 11:59 AM identified that on several occasions in November 2024 (unable to recall the exact dates) NA #3 was very rude to him/her and came into his/her room and stated, I just wipe your a**. Resident #1 reported that it upset him/her and he/she stated that on one occasion he/she replied to him, I don't give a s***. Resident #3 reported that he/she reported NA #3's behavior to OT #1, and she reported it to Social Worker #1 who came to speak with him/her but no one ever followed up with him/her on the resolution. Resident #3 identified that he/she didn't see NA #3 again until his/her room was changed to a different unit following a hospitalization in December 2024 and one day NA #3 just came into his/her room and started up and getting things ready to perform care. The resident reported that he/she was, Fearful. Fearful for my life at that time. Resident #3 reported that he/she said to him, We are not going to do this again, are we? and he said, No and was fine after that but reported that he/she doesn't let him touch him/her, stating, I just don't understand why they just don't get rid of him. Review of the grievance book failed to identify any Grievances from Resident #3 from October 2024 through January 2024. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Social Worker #1 on 2/14/25 at 10:48 AM identified that she is no longer employed by the facility and could not recall the incident, Resident #1 or NA #3. She identified that if another staff member had notified her of the allegation, she would have met with the resident and would have written up a grievance and placed it in the grievance book. Additionally, she identified that she should have met with the resident daily for 72 hours to offer support and stated that she should have documented her interactions in the progress notes but reported that she wasn't good about documenting and there weren't as many entries as there should have been. Review of social service notes from October 2024 through January 2025 failed to identify that Social Worker #1 met with Resident #3 following any allegations of abuse/neglect/mistreatment. Interview with OT #1 on 2/14/25 at 1:18 PM identified that she no longer works at the facility full-time but recalled Resident #3 reporting to her that sometime in December 2024, the resident had an incontinent episode on the 3:00 PM to 11:00 PM shift and NA #3 came into his/her room and unkindly stated he was there to wipe his/her a**, stating he/she was very upset and frustrated with the lack of care and compassion. OT #1 reported that Resident #1 reported the occurrence to her on the 7:00 AM to 3:00 PM on a weekend and she then reported the resident complaint to Social Worker #1, stating that Social Worker #1 went to speak with Resident #1 right away, stating that RN #1 (Day shift nursing supervisor) then suspended NA #3. She identified that several residents have had complaints regarding NA #3's care, and how he has left them on the toilet for extended periods of time but stated she had never personally received any other complaints from residents stating that NA #3 was verbally or physically abusive. Further, she identified that she would not have documented this resident allegation in her treatment note, as she had notified Social Worker #1 per protocol. 2. Resident #4's diagnoses included Parkinson's Disease without dyskinesia (involuntary body movements) and without mention of fluctuations (changes in symptoms) and adjustment disorder with anxiety (significant anxiety and worry that develops in response to a stressful life event). The Resident Care Plan (RCP) dated 11/4/24 identified that Resident #4 has the potential for impaired psychosocial wellbeing related to the loss of independence and a new diagnosis of Parkinson's disease with interventions that included encouraging the resident to verbalize feelings, staff to listen to the resident with interest and give realistic, positive feedback and encouraging the resident to make routine daily decisions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12) indicative of moderately impaired cognition and required substantial assistance with toileting, bed mobility and transfers and required moderate assistance with personal hygiene. Interview with RN #1 on 2/13/25 at 12:28 PM identified that on a weekend in November 2024, NA #5 had approached her and reported that Resident #4 was afraid to fall asleep because he was fearful of NA #3. She identified that there were at least two (2) other resident complaints that same day and that she notified the DNS that they rose to the level of abuse and then she (RN #1) suspended NA #3 and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure if she had notified Social Worker #1 or what happened after that. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #5 on 2/13/25 at 1:47 PM identified that Resident #4's family member (Person #4) was visiting in November and the resident stated, I don't want that man (NA #3) in my room because he scares me. He is rough and he scares me. I did not sleep all night. She identified that she reported Resident #4's concern to RN #1 (nursing supervisor) but was unsure of what happened after that. Interview with Person #4 on 2/13/25 at 2:01 PM identified that there were several times that Resident #4 had stated that he/she was fearful of NA #3, but that staff were present and heard it so he/she did not report it. Person #4 identified that he/she didn't know what to think of the allegations, as Resident #4 had never complained about any other staff except for NA #3. He reported that no one from the facility had ever reached out to him to discuss the concerns that Resident #4 had been having. Review of the grievance book from October 2024 through December 2024 failed to identify a grievance regarding Resident #4. Review of social service notes from 11/8/24 through 12/31/24 failed to identify and social service documentation regarding an allegation of abuse/neglect/mistreatment or follow-up interactions. 3. Resident #5's diagnoses included cerebral infarction (blood flow to the brain is interrupted, causing brain tissue to die), vision loss and generalized muscle weakness. The Resident Care Plan (RCP) dated 11/8/24 identified Resident #5 is at risk for impaired coping and impaired psychosocial wellbeing related to recent cerebral infarction with left sided weakness with interventions that included encouraging the resident to establish own goals, assisting the resident as needed to achieve goals and providing positive reinforcement for their efforts. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required substantial assistance with toileting, personal hygiene and bed mobility and was dependent on staff for transfers. Interview with RN #1 on 2/13/25 at 12:28 PM identified that on a weekend in November 2024 identified that Resident #5 reported that he/she was afraid to ring the bell for assistance because he/she would be yelled at and chastised by NA #3. Review of the grievance book from October 2024 through December 2024 failed to identify a grievance regarding Resident #5. Review of social service notes from 11/8/24 through 12/31/24 failed to identify and social service documentation regarding an allegation of abuse/neglect/mistreatment or follow-up interactions. 4. Resident #6's diagnoses included mood disorder with depressive features, generalized muscle weakness and the need for assistance with personal care. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan (RCP) dated 10/28/24 identified Resident #6 is at risk for impaired psychosocial wellbeing related to unresolved home/family issues with interventions that included encouraging the resident to express feelings about roommate, family and staff, encouraging the resident to verbalize feelings, staff to listen to the resident with interest and assess and find the basis of the resident's problem and attempt to resolve. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required substantial assistance with toileting, personal hygiene, bed mobility and transfers. Interview with RN #1 on 2/13/25 at 12:28 PM identified that she was unable to recall what Resident #6's November 2024 allegation was in regards to NA #3 but reported that she notified the DNS that it rose to the level of abuse and then she (RN #1) suspended NA #3 (due to a total of 3 complaints/allegations of abuse in the same day) and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure if she had notified Social Worker #1 or what happened after that. Review of the grievance book from October 2024 through December 2024 failed to identify a grievance regarding Resident #6. Review of social service notes from 11/8/24 through 12/31/24 failed to identify and social service documentation regarding an allegation of abuse/neglect/mistreatment or follow-up interactions. Interview with the DNS and Administrator on 2/13/25 at 2:38 PM identified that they were unaware of Resident #3's allegation from 2/8/25, as no one had ever notified them, and they were unable to identify who the three (3) residents were that were referred to on the Employee Warning Record on NA #3 dated 11/20/24 which reported that three (3) residents reported rude, abrupt and rushed care/treatment by NA #3 on 11/16/24. Concerns included being dismissive when asking for items and coming across like he was annoyed and bothered when a resident asked for help and not being polite or speaking with a resident during care. They identified that although there should have been, they were unable to locate any grievances or investigations for that date to go along with the Employee Warning Record. The Administrator stated that although her name, along with RN #3 (previous DNS) were listed as participants on the Employee Warning Record dated 11/20/24, she identified that she could not recall being a part of write-up with RN #3 and NA #3, reporting that she was not the Administrator at the time but was the Director of Social Services and stated she was working in several different buildings and if RN #3 mentioned it to her, it was only in passing stating that she already took care of it. She identified that if she had met with the residents, she would have documented in the clinical record. Acknowledgement statement from NA #3 in reply to the 11/20/24 Employee Warning Record stated, There were several residents that night (11/16/24) that were dirty and acting out. If it seemed like I was being short or was distracted it was because I had multiple people needing immediate care and I was stressed. My tone may have seemed rude, I hope not, but at the time I was doing multiple things. I did not mean to be rude or seem upset. I love my job and my patients. I just need to take a breath between patients sometimes and I push myself into stress. I'm sorry. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 2/14/25 at 11:20 AM identified that for any allegations of abuse, a social worker is to meet with the resident daily for 72-hours and document the encounters in the clinical record, ensure a grievance form is filled out and forwarded to Administration, and communicate the resolution of the grievance to the complainant. She identified that she was unsure why there were no grievance forms or social service documentation for Residents #3, 4, 5 or 6. Interview with RN #3 (prior DNS) on 2/14/25 at 12:23 PM identified that she could recall NA #3 as having an off-putting personality, a blank affect and a long-distance stare but had observed him being calm and helpful in stressful situations. She reported that she could not recall an incident with Resident #3 being reported to her but stated she had texts on her phone from RN #1 from 11/17/24 reporting that there were three (3) resident/family complaints from Residents #4, #5 and #6 regarding NA #3. RN #3 identified that RN #1 stated that she spoke with NA #3 and he had a blank, odd look but had nothing to say and RN #3 replied back, Does this rise to the level of abuse? and RN #1 stated, No, customer service but reported that she (RN #1) obtained statements and placed them under RN #3's office door. She identified that she (RN #3) spoke with the three (3) residents when she came in the Monday after the incident but stated although she was unsure if full investigations were completed on Residents #4, #5 and #6, that they should have been. She identified that NA #3's statement in reply to the accusations sounded to her like the facility was short staffed and he (NA #3) wasn't supported by his co-workers. She identified that the three (3) complaints should have at least been documented on grievance forms and that Social Worker #1 was notified and should have met with all the residents for 72-hours and documented on her interactions and then met with them to go over the resolution but stated that Social Worker #1 was on her way out and many things didn't get done as they should have. She reported that she never followed up to ensure the grievances were completed. RN #3 reported that she remembered communicating to NA #3 that he was no longer allowed to care for Residents #4, #5 and #6, stating that the separation should have continued but could not recall if anything else was done or why there was no documentation of this or the investigation that led to NA #3 not being able to care for those residents. Review of the Concerns, Complaints and/or Grievances policy (undated) directed, in part, that concerns, complaints/grievances brought to the Administration's attention will be actively addressed for resolution and inform the resident/interested party of that outcome. Should a staff member overhear or be the recipient of a concern or complaint voiced by a resident, resident's representative, or another interested family member of a resident concerning the resident's treatment, care, violation of rights, etc. the staff member is encouraged to assist the resident, or person acting in the resident's behalf, to file a written concern or complaint with the facility and/or direct the concern/complaint to the Director of Social Services, Grievance Official. Should a concern or complaint be brought to the attention of the charge nurse/nursing supervisor attempts will be made to resolve/correct the issue. The charge nurse/nursing supervisor will fill out the Grievance Form which would include a concern/complaint and its resolution and submit the complete form to the facility Social Worker. If no satisfactory resolution can be achieved, the concern/complaint may be signed by the resident or the person filing the complaint or grievance on behalf of the resident.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the clinical record, facility documentation, facility policy and interviews for one (1) of six (6) residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from abuse when a staff member was observed pushing the resident into the wheelchair. The findings include: Resident #1 's diagnoses included dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and required supervision assistance with personal hygiene, transfers and ambulation. The Resident Care Plan (RCP) dated 1/20/25 identified that Resident #1 has impaired cognition related to a diagnosis of dementia with behaviors including aggression and striking out with interventions that included to provide two (2) staff for all care during the 3:00 PM to 11:00 PM shift for sundowning behaviors, staff to identify themselves and explain procedures prior to event, staff to refer to the time of day, date and recent events in their interactions with the resident, staff to speak slowly, clearly and repeat information as needed and staff to stress keywords and present one thought, question, or command at a time. Review of the facility Reportable Event (RE) report dated 1/26/25 identified that on 1/26/25 at 8:30 AM Resident #1 reported to a NA (NA #4) that a man walked into his/her room in the evening (10:00 PM) on 1/25/25 without saying anything to the resident and was rough and hit him/her multiple times, specifically on the side of his/her face. The resident was noted with a 3.5 centimeter by 3.5 cm red/purple bruise to the top of his/her right hand and a small scab with dried blood at the center was noted. The RE reported that the police were notified, the NA (NA #3) was suspended pending investigation and an investigation into the allegation was initiated. Review of the facility schedule dated 1/25/25 identified that LPN #1, NA #3 and NA #2 worked on Resident #1's unit on the 3:00 PM to 11:00 PM shift. Review of nurse's notes dated 1/25/25 failed to identify documentation related to the alleged incident. The facility Summary Report dated 1/28/25 identified that when the Nursing Supervisor (RN #1) interviewed the resident, Resident #1 reported that they had been punched by a guy and further made a fist with his/her right hand and brought it up to his/her face making a punching motion three (3) times between his/her right eye and nose. A full body assessment was completed, and the resident was noted to have a new bruise on the right dorsal (back side) hand, but no facial injuries were observed. The report stated that during the facility's investigation, it was identified that the NA in question (NA #3) was punched in the face by Resident #1 on the evening of the alleged incident (1/25/25) and it was witnessed by staff but at no time was NA #3 witnessed having inappropriately touched Resident #1. The report identified that the facility was not substantiating the allegation of abuse by NA #3, as Resident #1 has diagnoses of dementia with behaviors, a known history of combative and sundowning behaviors and the resident was observed punching NA #3 and lacked facial bruising or redness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of statement with NA #1 on 2/13/25 at 10:56 AM identified that as she walked through the double doors onto Resident #1's unit on 1/25/25 around 10:00 PM, she heard yelling and stated as she approached Resident #1's room, she heard NA #3 telling Resident #1 to sit down and stop, as the resident was swearing at NA #3. NA #1 reported that as she entered the room, NA #3 was standing behind Resident #1 and then pushed Resident #1 down into the wheelchair by the tops of his/her shoulders, the push was not gentle, but a hard push She identified that Resident #1 stated numerous times for NA #3 to get away from him/her but NA#3 remained and the resident ended up hitting NA #3 in the face with his/her left hand. She identified that she then noticed that Resident #1's right hand was dripping blood (opposite hand that he/she hit NA #3 with) and the resident reported to her that it was because NA #3 punched him/her there and NA #3 came into the room and was trying to wipe the area with a paper towel. She identified that she then pushed the resident in the wheelchair to the nurse's station and notified LPN #1 and RN #2 (evening shift Nursing Supervisor) what had happened, but stated they blew her off and said they were busy, so she cleaned his/her right hand and put a band aid on the area and Resident #1 then allowed her to get him/her into bed as he/she stated to her several times to keep NA #3 away from him/her. NA #1 reported that she reapproached RN #2 again at the end of the shift when she (RN #2) was finished helping a resident with a tube feed, stating that she again explained what had happened. She identified that she didn't think RN #2 took her report seriously, so when she arrived to work at 7:00 AM on 1/26/25, she immediately notified RN #1 (day shift Nursing Supervisor). Additionally, she reported that she has not observed NA #3 on Resident #1's unit since she reported the incident to RN #1 on 1/26/25. Interview with RN #1 on 2/13/25 at 11:30 AM identified that NA #1 came up to her on 1/26/25 just after 7:00 AM reporting to her the incident that had happened the night before with Resident #1 and NA #3, stating she observed NA #3 pushing Resident #1 down by the shoulders into the wheelchair and yelling at him/her. She stated that RN #2 never reported the incident to her on shift-to-shift report so she called her on the phone, stating RN #2 admitted that NA #1 reported to her that she observed NA #3 pushing Resident #1 down into his/her wheelchair and stated she (RN #2) didn't report it to anyone. RN #1 identified that she directed RN #2 to call the Administrator, as the DNS was on vacation and she (RN #2) then interviewed Resident #1, completed a full assessment on the resident and then called the police, the family and the physician and then called NA #3 and told him not to come in that day on the 3:00 PM to 11:00 PM shift pending the investigation. RN #1 reported that she did not observe any marks to Resident #1's face but that she noted a bruise and skin tear with dried blood to the top of his/her right hand. Interview with RN #2 on 2/13/25 at 11:53 AM identified that at about 9:00 PM on 1/25/25, NA #1 approached her with Resident #1 in the wheelchair stating that Resident #1 hurt his/her hand and reported that NA #3 was yelling at Resident #1 but never reported that NA #3 was physical or pushed Resident #1, so she never sent NA #3 home. She identified that around 11:00 PM, NA #1 approached her again and stated that NA #3 shouldn't be caring for Resident #1 but stated she offered no explanation as to why. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS and Administrator on 2/13/25 at 1:03 PM identified that although NA #1 reported in her statement that NA #3 pushed Resident #1 down by the shoulders into the wheelchair, the facility unsubstantiated the allegation of abuse, as the resident had no marks showing that he/she had been punched and after they had NA #1 display to them how she observed NA #3 pushing Resident #1 down, they stated they didn't think it was forceful and did not constituted abuse. They identified that at that time, Resident #1 had been a two-staff for all care due to aggression and sundowning behavior and they were unsure why he had been caring for the resident alone, but stated that NA #3 should have requested assistance immediately after the resident requested that he stop and leave his/her room and should not have continued to try and provide care to the resident. Interview with LPN #1 on 2/13/25 at 1:19 PM identified that in the late evening on 1/26/25, NA #1 rolled Resident #1 up to her in the wheelchair and requested a band aid stating he/she hurt their hand but stated that NA #1 never reported to her that NA #3 was physically abusive to towards or pushed Resident #1. She identified that two (2) medical incidents had been going on at the time and it was a hectic night, stating she never followed up with the resident or NA #1, stating she saw RN #1 enter Resident #1's room prior to the end of the shift so she thought everything was taken care of. Interview with NA #3 on 2/13/25 at 1:28 PM identified that on 1/25/25, he was changing Resident #1's clothes when he/she stood up, became aggressive and started hitting his arms away and telling him to get off him/her and to get away from him/her. NA #3 reported that he never pushed the resident down into the wheelchair and stated he stepped back but did not leave the room because that was the resident's baseline. He identified that he was unsure why NA #1 would have said he pushed the resident down. Interview with NA #4 on 2/13/25 at 1:39 PM identified that on 1/26/25 when she went to go provide morning care to Resident #1, he/she reported that a man had hit him/her in the head the previous night. She stated he/she was insistent and kept yelling that violence was wrong but was unable to identify the person's name. She stated that she thought it was unusual because she hadn't seen the resident shaken up like that previously, stating that he/she was calm with no complaints the previous day. Review of the Abuse Prevention policy (undated) directed, in part, that the facility will not condone any form of resident abuse or neglect, and all personnel is to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting and kicking. Mistreatment means inappropriate treatment or exploitation of a resident. During abuse investigations, residents will be protected from harm and any employee accused of participating in an alleged abuse will be subjected to suspension during the course of the investigation. All reports of resident abuse shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation will interview staff members (on all applicable shifts) who have had contact with the resident during the period of the alleged incident, interview other residents to whom the accused employee provides care or services when indicated and review all events leading up to the alleged incident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility documentation, facility policy, and interviews for four (4) of six (6) residents (Residents #3, 4, 5 and 6) reviewed for abuse, the facility failed to ensure the State Agency was notified of allegations of abuse/mistreatment timely. The findings include: 1. Resident #3's diagnoses included anxiety disorder and depression. The Resident Care Plan (RCP) dated 10/28/24 identified Resident #3 has the potential for impaired psychosocial wellbeing related to the loss of independence and the need for assistance. Interventions included encouraging the resident to verbalize feelings and make routine daily decisions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was dependent on staff for personal hygiene, toileting, bed mobility and transfers. Interview with Resident #3 on 2/13/25 at 11:59 AM identified that on several occasions in November 2024 (unable to recall the exact dates) NA #3 was very rude to him/her and came into his/her room and stated, I just wipe your a**. Resident #3 reported that it upset him/her and he/she stated that on one occasion he/she replied to him, I don't give a s***. Resident #3 reported that he/she reported NA #3's behavior to OT #1, and she reported it to Social Worker #1 who came to speak with him/her but no one ever followed up with him/her on the resolution. Resident #3 identified that he/she didn't see NA #3 again until his/her room was changed to a different unit following a hospitalization in December 2024 and one day NA #3 just came into his/her room and started up and getting things ready to perform care. The resident reported that he/she was, Fearful. Fearful for my life at that time. Resident #3 reported that he/she said to him, We are not going to do this again, are we? and he said, No and was fine after that but reported that he/she doesn't let him touch him/her, stating, I just don't understand why they just don't get rid of him. Interview with OT #1 on 2/14/25 at 1:18 PM identified that she no longer works at the facility full-time but recalled Resident #3 reporting to her that sometime in December 2024, the resident had an incontinent episode on the 3:00 PM to 11:00 PM shift and NA #3 came into his/her room and unkindly stated he was there to wipe his/her a**, stating he/she was very upset and frustrated with the lack of care and compassion. OT #1 reported that Resident #1 reported the occurrence to her on the 7:00 AM to 3:00 PM on a weekend and she then reported the resident complaint to Social Worker #1, stating that Social Worker #1 went to speak with Resident #1 right away, stating that RN #1 (Day shift nursing supervisor) then suspended NA #3. She identified that several residents have had complaints regarding NA #3's care, and how he has left them on the toilet for extended periods of time but stated she had never personally received any other complaints from residents stating that NA #3 was verbally or physically abusive. Further, she identified that she would not have documented this resident allegation in her treatment note, as she had notified Social Worker #1 per protocol. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	475 High St Mystic, CT 06355

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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 - Some	Interview with Social Worker #1 on 2/14/25 at 10:48 AM identified that she is no longer employed by the facility and could not recall the incident, Resident #1 or NA #3 stating the facility used a lot of agency staff at that time and she could not recall anyone's name. She identified that if another staff had notified her of the allegation, she would have met with the resident and would have written up a grievance and placed it in the grievance book. Additionally, she identified that she should have met with the resident daily for 72 hours to offer support and stated that she should of documented her interactions in the progress notes but reported that she wasn't good about documenting and there weren't as many entries on residents as there should have been. Review of the State Agency Reportable Events website on 2/13/25 failed to identify the allegation of abuse/mistreatment was reported to the State Agency. 2. Resident #4's diagnoses included Parkinson's Disease without dyskinesia (involuntary body movements) and without mention of fluctuations (changes in symptoms) and adjustment disorder with anxiety (significant anxiety and worry that develops in response to a stressful life event). The Resident Care Plan (RCP) dated 11/4/24 identified that Resident #4 has the potential for impaired psychosocial wellbeing related to the loss of independence and a new diagnosis of Parkinson's disease. Interventions included encouraging the resident to verbalize feelings, staff to listen to the resident with interest and give realistic, positive feedback and encouraging the resident to make routine daily decisions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12) indicative of moderately impaired cognition and required substantial assistance with toileting, bed mobility and transfers and required moderate assistance with personal hygiene. Interview with RN #1 on 2/13/25 at 12:28 PM identified that on a weekend in November 2024, NA #5 had approached her and reported that Resident #4 was afraid to fall asleep because he was fearful of NA #3. She identified that there were at least two (2) other resident complaints that same day and that she notified the DNS that they rose to the level of abuse and then she (RN #1) suspended NA #3 and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure of what happened after that. Interview with NA #5 on 2/13/25 at 1:47 PM identified that Resident #4's family member (Person #4) was visiting in November and the resident stated, I don't want that man (NA #3) in my room because he scares me. He is rough and he scares me. I did not sleep all night. She identified that she reported Resident #4's concern to RN #1 (nursing supervisor) but was unsure of what happened after that. Interview with Person #4 on 2/13/25 at 2:01 PM identified that there were several times that Resident #4 had stated that he/she was fearful of NA #3, but that staff were present and heard it so he/she did not report it. Person #4 identified that he/she didn't know what to think of the allegations, as Resident #4 had never complained about any other staff except for NA #3. He reported that no one from the facility had ever reached out to him to discuss the concerns that Resident #4 had been having. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the State Agency Reportable Events website on 2/13/25 failed to identify the allegation of abuse/mistreatment was reported to the State Agency. 3. Resident #5's diagnoses included cerebral infarction (blood flow to the brain is interrupted, causing brain tissue to die), vision loss and generalized muscle weakness. The Resident Care Plan (RCP) dated 11/8/24 identified Resident #5 is at risk for impaired coping and impaired psychosocial wellbeing related to recent cerebral infarction with left sided weakness. Interventions included encouraging the resident to establish own goals, assisting the resident as needed to achieve goals and providing positive reinforcement for their efforts. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required substantial assistance with toileting, personal hygiene and bed mobility and was dependent on staff for transfers. Interview with RN #1 on 2/13/25 at 12:28 PM identified that on a weekend in November 2024, she had three (3) resident complaints the same day, Resident #5, who reported that he/she was afraid to ring the bell for assistance because he/she would be yelled at and chastised by NA #3. RN #1 notified the DNS that they rose to the level of abuse and then she (RN #1) suspended NA #3 and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure of what happened after that. Review of the State Agency Reportable Events website on 2/14/25 failed to identify the allegation of abuse/mistreatment was reported to the State Agency. 4. Resident #6's diagnoses included mood disorder with depressive features, generalized muscle weakness and the need for assistance with personal care. The Resident Care Plan (RCP) dated 10/28/24 identified Resident #6 is at risk for impaired psychosocial wellbeing related to unresolved home/family issues. Interventions included encouraging the resident to express feelings about roommate, family and staff, encouraging the resident to verbalize feelings, staff to listen to the resident with interest and assess and find the basis of the resident's problem and attempt to resolve. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required substantial assistance with toileting, personal hygiene, bed mobility and transfers. Interview with RN #1 on 2/13/25 at 12:28 PM identified that she was unable to recall what Resident #6's November 2024 allegation was in regards to NA #3 but reported that she notified the DNS that it rose to the level of abuse and then she (RN #1) suspended NA #3(due to a total of 3 complaints/allegations the same day) and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure of what happened after that. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the State Agency Reportable Events website on 2/14/25 failed to identify the allegation of abuse/mistreatment was reported to the State Agency. Interview with the DNS and Administrator on 2/13/25 at 2:38 PM identified that they were unable to identify who the three (3) residents were that were referred to on the Employee Warning Record on NA #3 dated 11/20/24 which reported that three (3) residents reported rude, abrupt and rushed care/treatment by NA #3 on 11/16/24. Concerns included being dismissive when asking for items and coming across like he was annoyed and bothered when a resident asked for help and not being polite or speaking with a resident during care. They identified that they were unable to locate any grievances or investigations for that date to go along with the Employee Warning Record, but identified that according to what was written, the allegations should have been reported to the State Agency and then investigated. Interview with RN #3 (prior DNS) on 2/14/25 at 12:23 PM identified that she could recall NA #3 as having an off-putting personality, a blank affect and a long-distance stare but had observed him being calm and helpful in stressful situations. She reported that she could not recall an incident with Resident #3 being reported to her but stated she had texts on her phone from RN #1 from 11/17/24 reporting that there were three (3) resident/family complaints from Residents #4, #5 and #6 regarding NA #3. RN #3 identified that RN #1 stated that she spoke with NA #3 and he had a blank, odd look but had nothing to say and RN #3 replied back, Does this rise to the level of abuse? and RN #1 stated, No, customer service but reported that she (RN #1) obtained statements and placed them under RN #3's office door. She identified that she (RN #3) spoke with the three (3) residents when she came in the Monday after the incident but stated although she was unsure if full investigations were completed on Residents #4, #5 and #6 that they should have been. She reported that she had multiple calls and texts to and from RN #8 (Regional) on 11/20/24 regarding reporting the allegations but stated she couldn't fit the complaints into the seven (7) abuse categories, so she did not report the allegations to the State Agency. Review of the Abuse Prevention policy (undated) directed, in part, that the facility will not condone any form of resident abuse or neglect, and all personnel is to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting and kicking. Mistreatment means inappropriate treatment or exploitation of a resident. During abuse investigations, residents will be protected from harm and any employee accused of participating in an alleged abuse will be subjected to suspension during the course of the investigation. All reports of resident abuse shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation will interview staff members (on all applicable shifts) who have had contact with the resident during the period of the alleged incident, interview other residents to whom the accused employee provides care or services when indicated and review all events leading up to the alleged incident. Any allegation or incident of abuse will be reported immediately but no later than within two (2) hours of the allegation or occurrence to the Department of Public Health (DPH).

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for five (5) of six (6) residents (Residents #2, 3, 4, 5 and 6) reviewed for abuse, the facility failed to investigate allegations of abuse or neglect and failed to ensure a complete investigation was completed on Resident #1. The findings include: 1. Resident #1 's diagnoses included dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and required supervision assistance with personal hygiene, transfers and ambulation. The Resident Care Plan (RCP) dated 1/20/25 identified that Resident #1 has impaired cognition related to a diagnosis of dementia with behaviors including aggression and striking out with interventions that included to provide two (2) staff for all care during the 3:00 PM to 11:00 PM shift for sundowning behaviors, staff identify themselves and explain procedures prior to event, staff to refer to the time of day, date and recent events in their interactions with the resident, staff to speak slowly, clearly and repeat information as needed and staff to stress keywords and present one thought, question, or command at a time. Review of the facility Reportable Event (RE) report dated 1/26/25 identified that on 1/26/25 at 8:30 AM Resident #1 reported to a NA (NA #4) that a man walked into his/her room in the evening (10:00 PM) on 1/25/25 without saying anything to the resident and was rough and hit him/her multiple times, specifically on the side of his/her face. The resident was noted with a 3.5 centimeter by 3.5 cm red/purple bruise to the top of his/her right hand and a small scab with dried blood at the center was noted. The RE reported that the police were notified, the NA (NA #3) was suspended pending investigation and an investigation into the allegation was initiated. Statements from NA #1, NA #3, NA #4 and Resident #1 were attached. Review of the facility schedule dated 1/25/25 identified that RN #2 (evening nursing supervisor), LPN #1, NA #3 and NA #2 worked on Resident #1's unit on the 3:00 PM to 11:00 PM shift. The facility Summary Report dated 1/28/25 identified that when the Nursing Supervisor (RN #1) interviewed the resident, Resident #1 reported that they had been punched by a guy and further made a fist with his/her right hand and brought it up to his/her face making a punching motion three (3) times between his/her right eye and nose. A full body assessment was completed, and the resident was noted to have a new bruise on the right dorsal (back side) hand, but no facial injuries were observed. The report stated that during the facility's investigation, it was identified that the NA in question (NA #3) was punched in the face by Resident #1 on the evening of the alleged incident (1/25/25) and it was witnessed by staff but at no time was NA #3 witnessed having inappropriately touching Resident #1. The report identified that the facility was not substantiating the allegation of abuse by NA #3, as Resident #1 has diagnoses of dementia with behaviors, a known history of combative and sundowning behaviors and the resident was observed punching NA #3 and lacked facial bruising or redness. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS and Administrator on 2/13/25 at 1:03 PM identified that although they should have obtained statements from all staff working on Resident #1's unit at the time of the allegation and any staff involved to complete a full investigation, they were unsure why they had not obtained statements from RN #2 (evening nursing supervisor), LPN #1 or NA #2. 2. Resident #2's diagnoses included anxiety disorder and other specified depressive episodes. The Resident Care Plan (RCP) dated 12/24/24 identified that Resident #2 has a history of exhibiting paranoid behavior or suspiciousness related to treatment. Interventions included to monitor the resident for triggers and avoid them in the future and when directed towards specific staff members, provide a substitute staff for the resident, establish and maintain routines, provide diversional activities and stimulation, provide consistent caregivers and allowing the resident choices and decision making. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was dependent on staff for toileting and transfers and required substantial assistance with personal hygiene. Interview with NA #1 on 2/13/25 at 10:56 AM identified that on the 3:00 PM to 11:00 PM shift on 2/8/25, Resident #2 reported to her that NA #3 came into his/her room and told him/her that he got in trouble and lost three (3) days of pay because of Resident #1 and NA #1 reporting that he pushed Resident #1. She reported that Resident #2 stated that he/she didn't feel comfortable around NA #3. NA #1 identified that she notified her charge nurse (RN #6). Interview with Resident #2 on 2/13/25 at 11:06 AM identified that NA #3 is very rude, telling him/her on more than one occasion that he's there to, wipe her a**, talking inappropriately to him/her and about other residents. Resident #2 reported that last Saturday (2/8/25), NA #3 complained to him/her that he was suspended for grabbing and yanking Resident #1 and that he lost money because of it and if he has one more complaint the facility told him he'd be let go. Resident #2 identified that he/she feels like he's on the edge mentally and is afraid he's going to get ahold of a firearm and have at it. Resident #2 identified that he/she reported this to NA #1 and LPN #2. Review of nurse's notes dated 2/7/25 through 2/13/25 failed to identify any resident complaints/issues regarding a staff member. Review of the grievance book from January to February 2025 failed to identify a grievance from Resident #2. Interview with RN #6 on 2/14/25 at 12:16 PM identified that NA #1 was her unit NA on 2/8/25 on the 3:00 PM to 11:00 PM shift, but stated NA #1 never reported to her an allegation or complaint regarding NA #3 from Resident #2, stating LPN #2 was responsible for Resident #2 that evening. Interview with LPN #2 on 2/14/25 at 1:45 PM identified that neither staff nor residents made a complaint to her regarding NA #3 on 2/8/25. She reported that she didn't really know NA #3, as she floats and doesn't work him often but stated she has never received a complaint regarding NA #3. She identified that if a resident was alleging a care concern or abuse she would have notified the nursing supervisor immediately. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #1 (nursing supervisor) on 2/14/25 at 9:25 AM identified that she could not recall anyone notifying her that Resident #2 had an allegation/complaint regarding NA #3 on 2/8/25, stating she had received no complaints in a few weeks. 3. Resident #3's diagnoses included anxiety disorder and depression. The Resident Care Plan (RCP) dated 10/28/24 identified Resident #3 has the potential for impaired psychosocial wellbeing related to the loss of independence and the need for assistance. Interventions included encouraging the resident to verbalize feelings and make routine daily decisions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was dependent on staff for personal hygiene, toileting, bed mobility and transfers. Interview with Resident #3 on 2/13/25 at 11:59 AM identified that on several occasions in November 2024 (unable to recall the exact dates) NA #3 was very rude to him/her and came into his/her room and stated, I just wipe your a**. Resident #1 reported that it upset him/her and he/she stated that on one occasion he/she replied to him, I don't give a s***. Resident #3 reported that he/she reported NA #3's behavior to OT #1, and she reported it to Social Worker #1 who came to speak with him/her but no one ever followed up with him/her on the resolution. Resident #3 identified that he/she didn't see NA #3 again until his/her room was changed to a different unit following a hospitalization in December 2024 and one day NA #3 just came into his/her room and started up and getting things ready to perform care. The resident reported that he/she was, Fearful. Fearful for my life at that time. Resident #3 reported that he/she said to him, We are not going to do this again, are we? and he said, No and was fine after that but reported that he/she doesn't let him touch him/her, stating, I just don't understand why they just don't get rid of him. Review of nurse's notes from 11/1/24 through 1/1/25 failed to identify any issues or resident complaints with staff members. Review of the grievance book failed to identify any Grievances from Resident #3 from October 2024 through January 2024. Interview with Social Worker #1 on 2/14/25 at 10:48 AM identified that she is no longer employed by the facility and could not recall the incident, Resident #1 or NA #3 stating the facility used a lot of agency staff at that time and she could not recall anyone's name. She identified that if another staff had notified her of the allegation, she would have met with the resident and would have written up a grievance and placed it in the grievance book. Additionally, she identified that she should have met with the resident daily for 72 hours to offer support and stated that she should of documented her interactions in the progress notes but reported that she wasn't good about documenting and there weren't as many entries on residents as there should have been. Review of social service notes from October 2024 through January 2025 failed to identify that Social Worker #1 met with Resident #3 following any allegations of abuse/neglect/mistreatment. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with OT #1 on 2/14/25 at 1:18 PM identified that she no longer works at the facility full-time but recalled Resident #3 reporting to her that sometime in December 2024, the resident had an incontinent episode on the 3:00 PM to 11:00 PM shift and NA #3 came into his/her room and unkindly stated he was there to wipe his/her a**, stating he/she was very upset and frustrated with the lack of care and compassion. OT #1 reported that Resident #1 reported the occurrence to her on the 7:00 AM to 3:00 PM on a weekend and she then reported the resident complaint to Social Worker #1, stating that Social Worker #1 went to speak with Resident #1 right away, stating that RN #1 (Day shift nursing supervisor) then suspended NA #3. She identified that several residents have had complaints regarding NA #3's care, and how he has left them on the toilet for extended periods of time but stated she had never personally received any other complaints from residents stating that NA #3 was verbally or physically abusive. Further, she identified that she would not have documented this resident allegation in her treatment note, as she had notified Social Worker #1 per protocol. 4. Resident #4's diagnoses included Parkinson's Disease without dyskinesia (involuntary body movements) and without mention of fluctuations (changes in symptoms) and adjustment disorder with anxiety (significant anxiety and worry that develops in response to a stressful life event). The Resident Care Plan (RCP) dated 11/4/24 identified that Resident #4 has the potential for impaired psychosocial wellbeing related to the loss of independence and a new diagnosis of Parkinson's disease. Interventions included encouraging the resident to verbalize feelings, staff to listen to the resident with interest and give realistic, positive feedback and encouraging the resident to make routine daily decisions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12) indicative of moderately impaired cognition and required substantial assistance with toileting, bed mobility and transfers and required moderate assistance with personal hygiene. Interview with RN #1 on 2/13/25 at 12:28 PM identified that on a weekend in November 2024, NA #5 had approached her and reported that Resident #4 was afraid to fall asleep because he was fearful of NA #3. She identified that there were at least two (2) other resident complaints that same day and that she notified the DNS that they rose to the level of abuse and then she (RN #1) suspended NA #3 and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure of what happened after that. Interview with NA #5 on 2/13/25 at 1:47 PM identified that Resident #4's family member (Person #4) was visiting in November and the resident stated, I don't want that man (NA #3) in my room because he scares me. He is rough and he scares me. I did not sleep all night. She identified that she reported Resident #4's concern to RN #1 (nursing supervisor) but was unsure of what happened after that. Interview with Person #4 on 2/13/25 at 2:01 PM identified that there were several times that Resident #4 had stated that he/she was fearful of NA #3, but that staff were present and heard it so he/she did not report it. Person #4 identified that he/she didn't know what to think of the allegations, as Resident #4 had never complained about any other staff except for NA #3. He reported that no one from the facility had ever reached out to him to discuss the concerns that Resident #4 had been having. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurse's notes from 11/1/24 through 1/1/25 failed to identify any issues or resident complaints with staff members. Review of the grievance book from October 2024 through December 2024 failed to identify a grievance regarding Resident #4. 5. Resident #5's diagnoses included cerebral infarction (blood flow to the brain is interrupted, causing brain tissue to die), vision loss and generalized muscle weakness. The Resident Care Plan (RCP) dated 11/8/24 identified Resident #5 is at risk for impaired coping and impaired psychosocial wellbeing related to recent cerebral infarction with left sided weakness. Interventions included encouraging the resident to establish own goals, assisting the resident as needed to achieve goals and providing positive reinforcement for their efforts. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required substantial assistance with toileting, personal hygiene and bed mobility and was dependent on staff for transfers. Interview with RN #1 on 2/13/25 at 12:28 PM identified that on a weekend in November 2024, she had three (3) resident complaints the same day and that she notified the DNS that they rose to the level of abuse and then she (RN #1) suspended NA #3 and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure of what happened after that. Re-interview with RN #1 on 2/14/25 at 9:25 AM identified that one (1) of the three (3) complaints was from Resident #5, who reported that he/she was afraid to ring the bell for assistance because he/she would be yelled at and chastised by NA #3. Review of nurse's notes from 11/1/24 through 1/1/25 failed to identify any issues or resident complaints with staff members. Review of the grievance book from October 2024 through December 2024 failed to identify a grievance regarding Resident #5. 6. Resident #6's diagnoses included mood disorder with depressive features, generalized muscle weakness and the need for assistance with personal care. The Resident Care Plan (RCP) dated 10/28/24 identified Resident #6 is at risk for impaired psychosocial wellbeing related to unresolved home/family issues. Interventions included encouraging the resident to express feelings about roommate, family and staff, encouraging the resident to verbalize feelings, staff to listen to the resident with interest and assess and find the basis of the resident's problem and attempt to resolve. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and required substantial assistance with toileting, personal hygiene, bed mobility and transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075271	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	475 High St Mystic, CT 06355

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #1 on 2/13/25 at 12:28 PM identified that she was unable to recall what Resident #6's November 2024 allegation was in regards to NA #3 but reported that she notified the DNS that it rose to the level of abuse and then she (RN #1) suspended NA #3 (due to a total of 3 complaints/allegations the same day) and sent him home pending the investigation but was not directed by the DNS to initiate a Reportable Event. She identified that she obtained statements and put them under RN #3's (previous DNS) office door but was unsure of what happened after that. Review of nurse's notes from 11/1/24 through 1/1/25 failed to identify any issues or resident complaints with staff members. Review of the grievance book from October 2024 through December 2024 failed to identify a grievance regarding Resident #6. Interview with the DNS and Administrator on 2/13/25 at 2:38 PM identified that they were unaware of Resident #2's allegation from 2/8/25, as no one had ever notified them, and they were unable to identify who the three (3) residents were that were referred to on the Employee Warning Record on NA #3 dated 11/20/24 which reported that three (3) residents reported rude, abrupt and rushed care/treatment by NA #3 on 11/16/24. Concerns included being dismissive when asking for items and coming across like he was annoyed and bothered when a resident asked for help and not being polite or speaking with a resident during care. They identified that they were unable to locate any grievances or investigations for that date, however, identified that according to what was written, and any other allegations of abuse/neglect/mistreatment are to be reported to the State Agency and then investigated. Review of the Abuse Prevention policy (undated) directed, in part, that the facility will not condone any form of resident abuse or neglect, and all personnel is to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting and kicking. Mistreatment means inappropriate treatment or exploitation of a resident. During abuse investigations, residents will be protected from harm and any employee accused of participating in an alleged abuse will be subjected to suspension during the course of the investigation. All reports of resident abuse shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation will interview staff members (on all applicable shifts) who have had contact with the resident during the period of the alleged incident, interview other residents to whom the accused employee provides care or services when indicated and review all events leading up to the alleged incident. Any allegation or incident of abuse will be reported immediately but no later than within two (2) hours of the allegation or occurrence to the Department of Public Health (DPH).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of six (6) residents (Resident #1) reviewed for abuse, the facility failed to ensure there was two (2) staff present for care of the 3:00 PM to 11:00 PM shift on 1/25/25 per the resident's plan of care. The findings include: Resident #1 's diagnoses included dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of three (3) indicative of severely impaired cognition and required supervision assistance with personal hygiene, transfers and ambulation. The Resident Care Plan (RCP) dated 1/20/25 identified that Resident #1 has impaired cognition related to a diagnosis of dementia with behaviors including aggression and striking out with interventions included to provide two (2) staff for all care during the 3:00 PM to 11:00 PM shift for sundowning behaviors, staff to identify themselves and explain procedures prior to event, staff to refer to the time of day, date and recent events in their interactions with the resident, staff to speak slowly, clearly and repeat information as needed and staff to stress keywords and present one thought, question, or command at a time. Review of Resident #1's Care Card identified that there was to be two (2) staff for all care during the 3:00 PM to 11:00 PM shift for sundowning/behaviors. Review of the facility Reportable Event (RE) report dated 1/26/25 identified that on 1/26/25 at 8:30 AM Resident #1 reported to a NA (NA #4) that a man walked into his/her room in the evening (10:00 PM) on 1/25/25 without saying anything to the resident and was rough and hit him/her multiple times, specifically on the side of his/her face. It identified that the resident was noted with a 3.5 centimeter by 3.5 cm red/purple bruise to the top of his/her right hand and a small scab with dried blood at the center was noted. The RE reported that the police were notified, the NA (NA #3) was suspended pending investigation and an investigation into the allegation was initiated. The facility Summary Report dated 1/28/25 identified that when the Nursing Supervisor (RN #1) interviewed the resident, Resident #1 reported that they had been punched by a guy and further made a fist with his/her right hand and brought it up to his/her face making a punching motion three (3) times between his/her right eye and nose. A full body assessment was completed, and the resident was noted to have a new bruise on the right dorsal (back side) hand, but no facial injuries were observed. The report stated that during the facility's investigation, it was identified that the NA in question (NA #3) was punched in the face by Resident #1 on the evening of the alleged incident (1/25/25) and it was witnessed by staff but at no time was NA #3 witnessed having inappropriately touching Resident #1. The report identified that the facility was not substantiating the allegation of abuse by NA #3, as Resident #1 has diagnoses of dementia with behaviors, a known history of combative and sundowning behaviors and the resident was observed punching NA #3 and lacked facial bruising or redness. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of statement with NA #1 on 2/13/25 at 10:56 AM identified that as she walked through the double doors onto Resident #1's unit on 1/25/25 around 10:00 PM, she heard yelling and stated as she approached Resident #1's room, she heard NA #3 telling Resident #1 to sit down and stop, as the resident was swearing at NA #3. NA #1 reported that as she entered the room, NA #3 was standing behind Resident #1 and then pushed Resident #1 down into the wheelchair by the tops of his/her shoulders. She identified that she then noticed that Resident #1's right hand was dripping blood (opposite hand that he/she hit NA #3 with) and the resident reported to her that it was because NA #3 punched him/her there. Interview with the DNS and Administrator on 2/13/25 at 1:03 PM identified that at the time of the 1/25/25 allegation towards NA #3, Resident #1 had been a two-staff for all care due to aggression and sundowning behavior and they were unsure why he had been caring for the resident alone, as he should have been following the resident's Care Card, but stated that NA #3 should have requested assistance immediately after the resident requested that he stop and leave his/her room and should not have continued to try and provide care to the resident. Interview with NA #3 on 2/13/25 at 1:28 PM identified that on 1/25/25, he was changing Resident #1's clothes when he/she stood up, became aggressive and started hitting his arms away and telling him to get off him/her and to get away from him/her. NA #3 reported that he never pushed the resident down into the wheelchair and stated he stepped back but did not leave the room because that was the resident's baseline. Additionally, although the plan of care was updated on 1/20/25 (5-days prior to the allegation) stating that Resident #1 was to have two (2) staff for all care during the 3:00 PM to 11:00 PM shift for sundowning/behaviors, he reported that he was not aware of the update and that no one had communicated the change to him, but stated he should always follow the resident's care card. Although requested, a policy on Resident Care Cards was not obtained.