

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/25/2025
NAME OF PROVIDER OR SUPPLIER  Mystic Healthcare & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  475 High St Mystic, CT 06355	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from verbal mistreatment. The findings include: Resident #1 was admitted with diagnoses that included stroke with resultant hemiplegia and hemiparesis (loss of movement on one side of the body), anxiety, and major depression. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 (was alert and oriented), and was dependent for toileting, transfers and bed mobility. The Resident Care Plan (RCP) dated 8/18/2025 identified Resident #1 was frequently incontinent of bowel and bladder was long term placement. The RCP directed to provide incontinent care upon request, toilet upon request and staff to provide emotional support. A facility investigation (A &amp; I) report dated 8/28/2025 at 9:00 AM identified an allegation of staff-to-resident abuse regarding care provided by NA #1. NA #2 reported that on 8/27/2025, he heard NA #1 ask Resident #1 why are you even sh*****, you don't eat anything we give you. When I heard I had you on my assignment, I was pissed. A facility A &amp; I summary dated 9/2/2025 identified NA #1 denied the allegation and Resident #1 reported he/she did not remember the incident. Further, the summary identified the allegation of abuse was unsubstantiated, however NA #1's communication style and tone was inconsistent with the facility expectations. Interview with NA #2 on 9/16/2025 at 10:12 AM identified he went to assist NA #1 around dinner time on 8/27/2025 when Resident #1 asked for assistance to go to the bathroom. NA #3 was with him as well as she was on orientation. As he entered into the room, he observed NA #1 at the foot of Resident #1's bed facing Resident #1. NA #1 said in a loud voice, why are you even sh*****, you don't eat the food here. NA #2 stated he thought Resident #1 looked stunned. NA #2 stated NA #1 told Resident #1 that she was pissed when she found out Resident #1 was on her assignment. NA #1 told Resident #1 that he/she needed to use the bedpan and not go to the bathroom. NA #2 stated he told NA #1 that she shouldn't talk to a resident that way, and left to report the incident to the charge nurse (LPN #1) and the supervisor. NA #2 continued that he told the supervisor that NA #1 had yelled and was rude to Resident #1, and stated he later apologized to Resident #1 for NA #1's behavior. Interview with NA #3 on 9/16/2025 at 10:25 AM identified that she was orienting with NA #2 when they went to assist NA #1 to provide care for Resident #1. NA #3 stated she left the room and NA #1 and NA #2 stayed to assist Resident #1 to the bathroom. As she walked out of Resident #1's room and into the hallway, she heard NA #1 say loudly, why do you want to sh**, you don't even want to eat the food here. NA #2 later told her they needed to tell the supervisor and they both reported that NA #1 had yelled at Resident #1. Interview with NA #1 was not obtained during the survey. Interview with RN #1/nursing supervisor, on 9/16/2025 at 11:19 AM identified NA #2 notified her on 8/27/2025 around 10:00 PM that NA #1 was rude to Resident #1 and she did not ask for any specific information regarding the interaction because she was aware that NA #1 had been reported in the past as loud and directive in her communications with residents and that it had been addressed by the DON previously. She could not recall if NA #2 had identified that NA #1 was yelling or directive and he did not report that NA #1 had used vulgar language. RN #1 asked LPN #1 if any resident had complained about a staff member and LPN #1 reported no resident complaints were made. RN #1 stated she asked NA #1 if any residents had complaints and NA #1 had replied no. RN #1 stated she reminded NA #1 that the residents don't always know her style and that she needed to be mindful of her approach. RN #1 identified that if staff were observed to be yelling, directive towards residents or using vulgar language, she would consider that abusive. Interview with the DON on 9/16/2025 at 12:19 PM identified NA #2 had reported to her on 8/28/2025 at 9:00 AM that on 8/27/2025 evening at 5:00 PM, NA #1 had yelled at Resident #1 and had asked Resident #1 why did he/she need to sh** as he/she didn't eat the food and that NA #1 was pissed that she had Resident #1 on her assignment. The DON stated the facility investigation did not substantiate abuse, but determined that NA #1's communication style was inconsistent with the facility's expectations and terminated her employment. The facility's Reporting Abuse to Facility Management Policy directed in part, that it is the policy of the facility not to condone any form of resident abuse or neglect by anybody including staff members. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance, The facility's Resident Rights policy, dated July 2021, directed in part that the resident's living quarters are treated as their home and</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #1) reviewed for abuse and neglect, the facility failed to ensure staff reported an allegation of abuse timely. The findings include: Resident #1 was admitted with diagnoses that included stroke with resultant hemiplegia and hemiparesis (loss of movement on one side of the body), anxiety, and major depression. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 (was alert and oriented), and was dependent for toileting, transfers and bed mobility. 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Interview with NA #3 on 9/16/2025 at 10:25 AM identified that she was orienting with NA #2 when they went to assist NA #1 to provide care for Resident #1. NA #3 stated she left the room and NA #1 and NA #2 stayed to assist Resident #1 to the bathroom. As she walked out of Resident #1's room and into the hallway, she heard NA #1 say loudly, why do you want to sh**, you don't even want to eat the food here. NA #2 later told her they needed to tell the supervisor and they both reported that NA #1 had yelled at Resident #1. Interview with RN #1/nursing supervisor, on 9/16/2025 at 11:19 AM identified NA #2 notified her on 8/27/2025 around 10:00 PM that NA #1 was rude to Resident #1 and she did not ask for any specific information regarding the interaction because she was aware that NA #1 had been reported in the past as loud and directive in her communications with residents and that it had been addressed by the DON previously. She could not recall if NA #2 had identified that NA #1 was yelling or directive and he did not report that NA #1 had used vulgar language. RN #1 asked LPN #1 if any resident had complained about a staff member and LPN #1 reported no resident complaints were made. RN #1 stated she asked NA #1 if any residents had complaints and NA #1 had replied no. RN #1 stated she reminded NA #1 that the residents don't always know her style and that she needed to be mindful of her approach. RN #1 identified that if staff were observed to be yelling, directive towards residents or using vulgar language, she would consider that abusive. Interview failed to identify that RN #1 notified the DON of the allegation of abuse, initiated an incident report or removed NA #1 from the schedule/unit to protect residents from potential abuse. Interview with the DON on 9/16/2025 at 12:19 PM identified NA #2 had reported to her on 8/28/2025 at 9:00 AM that on 8/27/2025 evening at 5:00 PM, NA #1 had yelled at Resident #1 and had asked Resident #1 why did he/she need to sh** as he/she didn't eat the food and that NA #1 was pissed that she had Resident #1 on her assignment. The DON stated RN #1 should have notified her of the allegation on 8/27/2025 when NA #2 reported the allegation, and she did not know why she was not notified. The facility's Reporting Abuse to Facility Management Policy directed in part, that it is the policy of the facility not to condone any form of resident abuse or neglect by anybody including staff members. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance. All personnel should promptly report</p>		