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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews for one (1) of four (4) residents (Resident #1) reviewed for care plan implementation, the facility failed to ensure staff followed the resident's person-centered care plan and Resident Care Card, which directed a pureed diet and monitoring during meals for aspiration, as evidenced by staff providing snacks without knowledge of a resident's prescribed diet and the failure to prevent access to food inconsistent with the prescribed diet. The findings include: Resident #1's diagnoses included dementia, chronic obstructive pulmonary disease, and dysphagia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had severe short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of 2), was dependent on staff for eating and was independent with transfers in and out of bed and ambulation.The Resident Care Plan dated 1/30/26 identified Resident #1 was at risk of weight loss, exhibited wandering behaviors and was at risk of elopement. Interventions directed to provide a regular, pureed diet with thin liquids, provide cues to eat slowly, encourage the resident to remain upright after meals, offer snacks between meals and bedtime as appropriate, engage the resident in purposeful activities, and identify triggers for wandering.The Resident Care Card (a quick-reference tool that summarizes a resident's specific daily needs, safety requirements, and personal preferences for NAs to use during care) dated 2/8/26 directed a puree diet and to monitor Resident #1 during meals for aspiration. The RCC further directed to remove food from the whole room due to Resident #1 potentially food seeking from the roommate.Physician's orders dated 2/8/26 directed a regular, pureed texture diet with thin liquids.The nurse's note dated 2/8/26 at 8:02 AM by RN #1 (the 11:00 PM to 7:00 AM Supervisor) identified at approximately 4:45 AM, LPN #1 (the 11:00 PM to 7:00 AM charge nurse) reported that Resident #1 ate a piece of a peanut butter sandwich that he/she took from the food cart, located outside the locked kitchen door, and choked on it. The Heimlich maneuver was performed by LPN #1 and Resident #1 expelled the contents of the sandwich from his/her mouth.The APRN note dated 2/10/26 identified the APRN was asked to see Resident #1 due to a choking episode on 2/8/26. Resident #1 was referred to Speech Therapy for further evaluation and a chest x-ray was ordered to rule out aspiration.The APRN note dated 2/12/26 identified results of the chest x-ray were positive for bronchitis, and the physician directed antibiotics be started, a duo-neb treatment for three (3) days, to continue with aspiration precautions and follow-up with the Speech Pathologist.Interview with NA #1 (the 11:00 PM to 7:00 AM nurse aide) on 3/16/26 at 12:50 PM identified that sometime after 3:00 AM on 2/8/26, she was walking down the hall and saw Resident #1 by the food cart next to the locked kitchen door choking. NA #1 alerted LPN #1 who performed the Heimlich maneuver. NA #1 further identified Resident #1 habitually wandered up and down the hallway during the 11:00 PM to 7:00 AM shift looking for food. NA #1 identified she previously observed Resident #1 attempt taking food off the dirty food cart and witnessed Resident #1 take a bite of a sandwich from the food cart. NA #1 did not report the incidents because she thought staff were aware of the behavior. NA #1 was not aware Resident #1 was prescribed a pureed diet and further identified she would give Resident #1 snacks (typically chocolate pudding) during the (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night.Interview with the Director of Nursing (DON) on 3/16/26 at 2:10 PM and on 3/17/26 at 11:00 AM identified she was unaware that Resident #1 previously took a bite out of a sandwich retrieved from the food cart. NA #1 had not reported prior observations of Resident #1 attempting to take food or eat food from the food cart and NA #1 should have reported these incidents to a licensed nurse.Review of the Care Planning- Interdisciplinary Team policy directed, in part, that staff shall follow the plan of care and Care Card as applicable.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies and interviews for four (4) of four (4) sampled residents (Residents #1, #2, #3, and #4), reviewed for a safe environment, the facility failed to ensure the environment was safe from accidents or hazards, when a food cart containing meal trays was stored outside of the locked kitchen door overnight and was accessible to cognitively impaired residents, who were prescribed modified diets and had wandering behaviors, which created a choking hazard. Additionally, one (1) of four (4) sampled residents (Resident #1) experienced a choking episode requiring the Heimlich maneuver after accessing food from the unattended tray chart. This failure resulted in the finding of Immediate Jeopardy. The findings include: 1.Resident #1's diagnoses included dementia, chronic obstructive pulmonary disease, and dysphagia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had severe short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of 2), was dependent on staff for eating and was independent with transfers in and out of bed and ambulation.The Resident Care Plan dated 1/30/26 identified Resident #1 was at risk of weight loss, exhibited wandering behaviors and was at risk of elopement. Interventions directed to provide a regular, pureed diet with thin liquids, provide cues to eat slowly, encourage the resident to remain upright after meals, offer snacks between meals and bedtime as appropriate, engage the resident in purposeful activities, and identify triggers for wandering.Physician's orders dated 2/8/26 directed a regular, pureed texture diet with thin liquids.Physician's orders dated 2/8/26 directed a Wanderguard (an electronic monitoring device that alerts staff when at-risk (wandering) individuals approach or attempt to exit secured areas) for wandering and elopement risk.2.Resident #2's diagnoses included cerebral infarction, chronic obstructive pulmonary disease, and diabetes type two (2).The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had severe short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of 7), was independent with eating, and required moderate assistance from staff for transfers and ambulation.The Resident Care Plan dated 1/30/26 identified Resident #2 exhibited impaired nutrition and was at risk for wandering and elopement. Interventions directed a low concentrated sweet (LCS) diet, mechanical soft texture, and thin liquids, offer food in small portions, assist the resident to find his/her room on the unit, apply a Wanderguard Bracelet, and provide diversional activities as needed.Physician's orders dated 2/8/26 directed LCS, mechanical soft texture diet, thin liquid consistency.Physician's orders dated 2/8/26 directed a Wanderguard for wandering and elopement risk.3.Resident #3's diagnoses included dementia, diabetes type two (2), and dysphagia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had severe short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of (6), required set up assistance for meals, and used a wheelchair for mobilization.The Resident Care Plan dated 1/30/26 identified Resident #3 exhibited an alteration in nutrition status and was at risk for wandering and elopement. Interventions directed a LCS, no added salt (NAS), mechanical soft texture diet, and thin liquids, speech consults as needed, apply a Wanderguard Bracelet and provide diversional activities.Physician's orders dated 2/8/26 directed LCS, NAS, mechanical soft texture diet with thin liquids.Physician's orders dated 2/8/26 directed a Wanderguard for wandering and elopement risk.4.Resident #4's diagnoses included schizophrenia, anxiety, and dysphagia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had moderate short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of 11), was independent with eating, bed mobility, transfers, and ambulation.The Resident Care Plan dated 1/30/26 identified Resident #4 exhibited an alteration in nutrition status, was at risk for choking due to poor dental hygiene, and was at risk for wandering and elopement. Interventions directed a regular, mechanical soft texture diet, and thin liquids, speech consultations (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as needed, a Wanderguard Bracelet, and to provide diversional activities.Physician's orders dated 2/8/26 directed a regular, mechanical soft texture diet with thin liquids.Physician's orders dated 2/8/26 directed a Wanderguard for wandering and elopement risk.The nurse's note dated 2/8/26 at 8:02 AM by RN #1 (the 11:00 PM to 7:00 AM Supervisor) identified at approximately 4:45 AM, LPN #1 (the 11:00 PM to 7:00 AM charge nurse) reported that Resident #1 ate a piece of a peanut butter sandwich that he/she took from the food cart, located outside the locked kitchen door, and choked on it. The Heimlich maneuver was performed by LPN #1 and Resident #1 expelled the contents of the sandwich from his/her mouth. Resident #1 returned to baseline after eating the food from the food cart.The APRN note dated 2/10/26 identified the APRN was asked to see Resident #1 due to a choking episode on 2/8/26. Resident #1 was referred to Speech Therapy for further evaluation and a chest x-ray was ordered to rule out aspiration.The APRN note dated 2/12/26 identified results of the chest x-ray were positive for bronchitis, and the physician directed antibiotics be started, a duo-neb treatment for three (3) days, to continue with aspiration precautions and follow-up with the Speech Pathologist.Interview with the Director of Food Service on 3/16/26 at 12:00 PM and 3/17/26 at 9:45 AM identified the facility process for collecting meal trays was to take a food cart room to room, collect meal trays, scrape remaining food into the garbage attached to the side of the food cart and then return the food cart containing dirty dishes to the kitchen. When dietary staff left their shift at 7:30 PM, they would leave an empty food cart outside the locked kitchen door for staff to return remaining dishes not previously collected. The expectation was that the remaining food would be scraped into the garbage attached to the food cart. There was no cover on the food cart or attached garbage. The supervising nurse had access to the kitchen keys and was expected to lock the dirty food cart inside the kitchen, however, the food cart was not consistently locked in the kitchen. The Director of Food Service identified he previously reported to Administration that the food cart was not being stored inside the locked kitchen once the remaining meal trays were collected. The Director of Food Service further identified that a resident wandering, unattended, had the potential to access food from the food cart or attached garbage when the cart was left outside the kitchen door.Interview with NA #1 (the 11:00 PM to 7:00 AM nurse aide) on 3/16/26 at 12:50 PM identified that sometime after 3:00 AM on 2/8/26, she was walking down the hall and saw Resident #1 by the food cart next to the locked kitchen door choking. NA #1 alerted LPN #1 who performed the Heimlich maneuver. NA #1 further identified Resident #1 habitually wandered up and down the hallway during the 11:00 PM to 7:00 AM shift looking for food. Resident #1 had the ability to open the unit double doors and walk past the kitchen door which was beyond the double doors. NA #1 identified there were multiple occasions when she observed Resident #1 attempt taking food off the dirty food cart and one occasion when she witnessed Resident #1 take a bite of a sandwich from the food cart. NA #1 did not report the incidents because she thought staff were aware of the behavior. NA #1 was not aware Resident #1 was prescribed a pureed diet.Interview with SLP (Speech Language Pathologist) on 3/16/26 at 1:00 PM identified Resident #1 was admitted to the facility on a pureed diet due to a history of choking which required the Heimlich maneuver. All subsequent evaluations conducted by the SLP further identified a pureed diet was appropriate and the diet could not be upgraded due to a high risk of choking and aspiration.Interview with RN #1 on 3/16/26 at 2:20 PM identified the 2/8/26 shift was her first shift worked at the facility. RN #1 was not aware that a food cart was left outside of the locked kitchen door for the purpose of collecting meal trays and that she should have locked the food cart in the kitchen. RN #1 received facility training prior to working at the facility but the meal tray collection process was not a part of the training. Interview with Dietary Aide (DA) #1 (6:00 AM to 2:00 PM shift) on 3/17/26 at 10:06 AM identified his first task in the morning was emptying the plates from the food cart that was left in the hallway outside the locked kitchen doors overnight. DA #1 identified that sometimes food was left on the plates and sometimes food had been scraped into the garbage attached to the food cart. The garbage did not have a lid.Interview with the Director of Nursing (DON) on 3/16/26 at 2:10 PM and on 3/17/26 at 11:00 AM identified she was aware Resident #1 wandered (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	throughout the building and wore a Wanderguard. The DON identified no one reported Resident #1 was seeking out food when wandering or that Resident #1 had previously taken a bite out of a sandwich retrieved from the food cart. NA #1 had not reported prior observations of Resident #1 attempting to take food or eat food from the food cart and NA #1 should have reported these incidents to a licensed nurse. The DON further identified it was reported to her on different occasions that the food cart was being left outside the locked kitchen door and she addressed the issue with staff on more than one occasion. The DON identified it was the responsibility of the Supervisor to lock the food cart in the kitchen. She identified that 2/8/26 was RN #1's first shift worked at the facility and she received facility training prior to working.Review of the Building Specific Orientation Tour dated 2/7/26, provided to RN #1 prior to her first shift worked at the facility, did not identify training related to meal tray collection and food cart storage in the kitchen.Although attempted, an interview with LPN #1 was not obtained.The facility policy titled Safe and Homelike Environment identified, in part, that in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment which includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.The facility policy titled Elopements and Wandering Residents identified, in part, that the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy further identified the facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Although requested, the facility did not provide a policy to include food cart storage or proper disposal of food.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews for one (1) of four (4) residents (Resident #1) reviewed for a safe environment, the facility failed to ensure nursing staff were aware of a resident's prescribed diet and failed to ensure staff reported observed unsafe eating behaviors, resulting in a cognitively impaired resident accessing food inconsistent with the prescribed diet and experiencing a choking episode. The findings include: Resident #1's diagnoses included dementia, chronic obstructive pulmonary disease, and dysphagia.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had severe short and long-term memory recall deficits (Brief Interview for Mental Status (BIMS) score of 2), was dependent on staff for eating and was independent with transfers in and out of bed and ambulation.The Resident Care Plan dated 1/30/26 identified Resident #1 was at risk of weight loss, exhibited wandering behaviors and was at risk of elopement. Interventions directed to provide a regular, pureed diet with thin liquids, provide cues to eat slowly, encourage the resident to remain upright after meals, offer snacks between meals and bedtime as appropriate, engage the resident in purposeful activities, and identify triggers for wandering.Physician's orders dated 2/8/26 directed a regular, pureed texture diet with thin liquids.Physician's orders dated 2/8/26 directed a Wanderguard (an electronic monitoring device that alerts staff when at-risk (wandering) individuals approach or attempt to exit secured areas) for wandering and elopement risk.The nurse's note dated 2/8/26 at 8:02 AM by RN #1 (the 11:00 PM to 7:00 AM Supervisor) identified at approximately 4:45 AM, LPN #1 (the 11:00 PM to 7:00 AM charge nurse) reported that Resident #1 ate a piece of a peanut butter sandwich that he/she took from the food cart, located outside the locked kitchen door, and choked on it. The Heimlich maneuver was performed by LPN #1 and Resident #1 expelled the contents of the sandwich from his/her mouth.The APRN note dated 2/10/26 identified the APRN was asked to see Resident #1 due to a choking episode on 2/8/26. Resident #1 was referred to Speech Therapy for further evaluation and a chest x-ray was ordered to rule out aspiration.The APRN note dated 2/12/26 identified results of the chest x-ray were positive for bronchitis, and the physician directed antibiotics be started, a duo-neb treatment for three (3) days, to continue with aspiration precautions and follow-up with the Speech Pathologist.Interview with NA #1 (the 11:00 PM to 7:00 AM nurse aide) on 3/16/26 at 12:50 PM identified that sometime after 3:00 AM on 2/8/26, she was walking down the hall and saw Resident #1 by the food cart next to the locked kitchen door choking. NA #1 alerted LPN #1 who performed the Heimlich maneuver. NA #1 further identified Resident #1 habitually wandered up and down the hallway during the 11:00 PM to 7:00 AM shift looking for food. NA #1 identified she previously observed Resident #1 attempt taking food off the dirty food cart and witnessed Resident #1 take a bite of a sandwich from the food cart. NA #1 did not report the incidents because she thought staff were aware of the behavior. NA #1 was not aware Resident #1 was prescribed a pureed diet and further identified she would give Resident #1 snacks (typically chocolate pudding) during the night.Interview with the Director of Nursing (DON) on 3/16/26 at 2:10 PM and on 3/17/26 at 11:00 AM identified she was unaware that Resident #1 previously took a bite out of a sandwich retrieved from the food cart. NA #1 had not reported prior observations of Resident #1 attempting to take food or eat food from the food cart and NA #1 should have reported these incidents to a licensed nurse.